Bulletin

Edited by Michelle Riordan

Independent Review Office

RECENT CASES

These case reviews are not intended to substitute for the headnotes or ratios of the cases. You are strongly encouraged to read the full decisions. Some decisions are linked to AustLii, where available.

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Supreme Court of NSW Decisions

Judicial review - Denial of procedural fairness – Jurisdictional error – Failure to exercise jurisdiction – Failure to conduct new assessment – Irrelevant consideration – Failure to respond to a clearly articulated argument – Failure to provide reasons – Failure to inquire

Chahrouk v Allianz Australia Insurance Limited [2021] NSWSC 1457 – Harrison AsJ – 10/11/2021

On 14/07/2018, the plaintiff was involved in a MVA, in which he allegedly injured his neck, both shoulders, lower back and also suffered PTSD. He claimed damages, but the insurer his injuries to be "*minor injuries*" for the purposes of s 1.6 of the *MACA 2017,* which meant that he was not entitled to statutory weekly benefits after 26 weeks from the date of the MVA and was unable to claim damages.

The plaintiff sought an internal review of this decision, but the insurer affirmed it on review. He then lodged an application with the DRS and on 24/10/2019, Assessor Assem issued a MAC which stated that the injuries were soft tissue injuries and were not causally-related to the MVA.

On 21/11/2019, the plaintiff applied for a review of the MAC on the basis that it was infected with several material errors. On 26/10/2020, the Review Panel (RP) certified that the right shoulder injury was causally related to the MVA, but it was a minor injury, and the other injuries were not caused by the MVA.

The plaintiff applied to the Supreme Court of NSW for judicial review on 9 grounds and asserted that the RP erred in law, denied him procedural fairness on multiple grounds and committed jurisdictional error.

Harrison AsJ considered grounds (1), (2) and (3) together and identified the following issues:

(1) In relation to the right shoulder injury, whether the RP: (a) erred in law in determining that this was a soft tissue injury; (b) denied the plaintiff procedural fairness by failing to provide adequate reasoning why this injury was determined to be a soft tissue injury and not causally related to the accident; and (c) denied the plaintiff procedural fairness by failing to respond to a substantial and clearly articulated argument in his submissions; and (2) in relation to the other alleged injuries, whether the Review Panel denied the plaintiff procedural fairness by failing to provide adequate reasons for its decision that these were not causally related to the MVA.

Her Honour held that the plaintiff made a clearly articulated argument to the RP that the right shoulder injury was caused by the MVA and included a SLAP tear, which is distinct from a tendon injury. While the RP made a finding that the SLAP tear to the right shoulder was caused in the accident, it did not refer to the SLAP tear in its path of reasoning that arrived at the conclusion that the injury to the right shoulder was degenerative and thus a minor injury. The RP did not specifically refer to nor explain why the SLAP tear falls into the category of minor injury and it constructively failed to exercise its discretion and made an error on the face of the record. However, she rejected the plaintiff's arguments in relation to the other alleged injuries.

Her Honour considered grounds (5), (6), (7) and (8) together and rejected them. She held that when read in context, the RP's reference to many studies meant to convey that it was well know medical literature and formed part of their medical expertise. It was not necessary for the Review Panel to list the individual studies in their decision and the parties did not need an opportunity to address what is well known and accepted medical knowledge. Therefore, there was no denial of procedural fairness and the RP did not fail to give reasons.

Her Honour rejected ground (4) and held that the RP correctly identified the grounds of review and conducted a fresh examination.

Her Honour rejected ground (9) and held that the RP's duty to inquire does not require it to identify which parts of the plaintiff's history would be critical to its consideration and which would not. Rather, it was required to ask, and the plaintiff was required to answer, questions about the circumstances of the accident, his immediate symptoms and the treatment he had. The Medical Panel did so.

Accordingly, her Honour set aside the RP's decision and remitted the matter to the President of the PIC to be determined according to law.

PIC - Presidential Decisions

Section 60 WCA - Whether proposed surgery is reasonably necessary as a result of injury - Diab v NRMA Ltd [2014] NSWWCCPD 72 considered and applied

Summers v Sydney International Container Terminals Pty Limited t/as Hutchison Ports [2021] NSWPICPD 35 – President Phillips – 4/11/2021

The appellant injured his neck and back at work on 10/10/2019 (deemed date). The sole dispute was whether the proposed cervical decompression and fusion surgery was reasonably necessary as a result of that injury.

Member Wynyard determined that the proposed surgery was not reasonably necessary as a result of the work injury.

The appellant appealed against that decision and alleged that the Member erred as follows: (1) in fact and law in failing to find that the proposed surgery was reasonably necessary as a result of the injury; (2) in fact and law by erroneously understanding that he was seen once by the treating surgeon, which led to the Member's failure to appreciate the reliability and probative value of the doctor's assessment of the need for surgery; (3) in fact and law by overlooking the evidence provided by the nuclear bone scan which confirmed severe pathology at the C3/4 level; (4) in fact and law by purporting to rely on the report of Dr Dalton as indicating that the proposed surgery was not reasonably necessary; (5) in fact and law by relying on the opinion of Dr Rimmer, notwithstanding the manifest deficiencies in that opinion; (6) in fact by erroneously stating that Dr Bodel, on examination "*found them [sic] to be normal*", contrary to the abnormalities recorded by Dr Bodel in the same report; (7) in fact and law by failing to understand, and be guided by, the diagnostic relevance of the relief provided by the CT-guided injection at C3/4, and purporting to offer an unqualified medical opinion of his own; (8) in fact and law by not engaging with Dr Bodel's revised opinion, and relying on an earlier opinion which Dr Bodel changed in accordance with evidence he had not previously considered; (9) in fact and law by failing to acknowledge that on the date of the hearing the preponderance of medical opinion (as constituted by both Dr Singh and Dr Bodel) was that surgery at the C3/4 level was reasonably necessary; (10) in fact and law by considering that his case "*is dependent obviously on my being persuaded that Dr Singh knew that the x-ray dated 31 December 2019 [sic, October] demonstrated pathology that justified the*

surgery, but that all other medical specialists ignored the x-ray for whatever motive"; when his case was based on a substantially greater foundation than what was revealed in the October 2019 x-ray; (11) in fact and law by requiring pathology revealed by investigations to be "*overwhelming*" in order to provide a basis for surgery; (12) in fact and law by purporting to diminish Dr Singh's opinion as to the causal relationship between his condition and his employment (a matter that is not in dispute) by suggesting that Dr Singh was influenced by his solicitors, notwithstanding that Dr Singh had recorded that opinion in a letter to his GP on 3 March 2020; (13) in fact by finding that he sought a second opinion from Dr Bodel, whereas that opinion was sought from Dr Loefler; (14) in fact and law by preferring the opinions of the qualified doctors as to their interpretations of the radiology evidence over the opinion of specialist radiologists; (15) in fact and law in dismissing the radiologist's comment concerning the x-ray of 31/10/2019 of encroachment at the right C3/4 exit foramen as probably compressing the nerve root as "*hardly an overwhelming comment*"; and (16) in fact and law by diminishing the opinion of Dr Singh because of his failure to allegedly take "*a proper history of the circumstances*" of the injury when injury and causation were never an issue in the claim.

President Phillips determined the appeal. He noted that the appellant asserted that ground (1) identifies the Member's principal error and that grounds (2) to (15) are errors that ultimately contributed to the principal error. He therefore considered grounds (2) to (15) before ground (1).

His Honour rejected ground (2) and he held that although the Member had a number of concerns regarding his evaluation of Dr Sing's evidence, these are detailed in the decision and the fact that he erred regarding the number of consultations with the appellant had not affected those considerations.

His Honour rejected ground (3) and held that the appellant's assertion that the Member does not refer to the bone scan findings is not substantiated as it was specifically referred to.

His Honour rejected ground (4) and he stated that Dr Dalton's opinion was properly before the Member and it was a matter for the Member to give the opinion such weight as he thought necessary and there was no error in this approach. At no stage was it advanced before the Member that Dr Dalton could not offer an opinion on the proposed surgery and in any event, Dr Dalton did not offer an opinion about it.

His Honour rejected ground (5) and he stated, relevantly:

> 124. It is clear that the Arbitrator preferred the opinions of Drs Bodel, Dalton and Rimmer that surgical intervention was not reasonably necessary. In particular in relation to Dr Rimmer the Arbitrator said as follows:
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> > I accept in relation to the opinion by Dr Rimmer that the mainstay of his opinion was that there was no injury or the aggravation has ceased, but he did make that comment, as I said at the outset, that he couldn't see why the C3/4 level was appropriate…
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> 127. The fact that the precise questions complained of in Ground 5(a), (b) and (d) were not in terms addressed by Dr Rimmer does not in my opinion render his report to have no weight. In terms of Ground 5(c), this does not speak to the question of whether or not the proposed surgery was reasonably necessary. This does not constitute an error on the part of the Arbitrator. Notwithstanding the findings of error that I make later in this decision, the precise errors raised under Ground 5 have not been established.

His Honour upheld ground (6) and found that the Member erred in constraining Dr Bodel's reports as revealing the appellant's condition to be normal, when this is not the case. The descriptor "normal" was used as support for the ultimate opinion that the proposed surgery was not reasonably necessary and was thus made in error.

His Honour upheld ground (7) and he stated, relevantly:

> 150. Whilst the Commission is a specialised tribunal and in some respects can be seen as having experience enabling it to "*draw inferences from facts which an ordinary tribunal may not*", this expertise however can only be deployed to interpret or draw inferences from existing evidence, it cannot be used to create evidence.

151. In this circumstance, the Arbitrator had the opinions of two specialists, Dr Singh and Bodel, who gave their expert opinions on the significance of the relief the appellant experienced after the block injection at the C3/4 level. In those circumstances, the Arbitrator had to deal with those opinions and the argument clearly articulated regarding this matter (see [149] above). This was not a circumstance where an inference that a specialised tribunal may draw could arise in opposition to the specialist opinion.

His Honour also upheld ground (8) and he found that the Member had not dealt with Dr Bodel's second report and that this was an error.

His Honour rejected ground (9) and he stated that the evidence was as clearly delineated as the appellant asserted and when properly construed, the evidence shows various opinions and developing opinions as various investigations were undertaken. It would have been helpful to the Member if Dr Bodel had more clearly set out why his opinion changed.

His Honour also rejected ground (10) and found that a fair reading of the decision indicates that the Member considered more than the x-rays in October 2019 and that he grappled with the issue of the investigations.

His Honour considered grounds (11) and (15) together and he rejected both and stated, relevantly:

169. This appeal point can be shortly dealt with. It is abundantly clear from a fair reading of the Arbitrator's decision that he knew and applied the correct test as to whether or not the proposed surgery was reasonably necessary. The offending remark appears at reasons 9.1–2 where the Arbitrator said, having reviewed the x-ray report of 31 October 2019, "*[t]hat is hardly an overwhelming comment by the radiologist in any event*".

His Honour considered grounds (12) and (16) together and he rejected both. He stated, relevantly:

180. I do not consider that on any fair reading of the Arbitrator's decision, and in particular the section I have quoted from the foot of p 6 of the decision, could there be any suggestion that Dr Singh's opinion was somehow influenced by the appellant's solicitors or that he was otherwise making prejudicial assumptions. These were remarks which are available on a consideration of the entirety of Dr Singh's material, including Dr Singh's instructing letter from the appellant's solicitors. As can be seen from the above, Dr Singh had not in the first four pieces of correspondence set out in detail all of the history. This is not surprising because at that time he was concerned with providing advice and treatment to the appellant for his condition. But it can be said that no detailed history is recorded in that correspondence, and in saying this I am not being critical of the doctor at all. This was not the purpose of the correspondence which was taking place between Dr Singh and the general practitioners. But the Arbitrator was entitled to test the weight he would give to Dr Singh's opinion and in particular the factual basis that underpinned the opinion. There is nothing prejudicial in this undertaking.

181. Finally, in terms of Ground 16, it is not possible to discern from the first four reports authored by Dr Singh whether or not he had a complete history. Clearly though, from a consideration of the first four reports, Dr Singh was aware that the appellant had worked on the docks and had formed a view that the pathology that he was suffering from was related to that work, without going into the relationship between the work and the injury concerned, As I have said, this is no criticism of Dr Singh because the purpose of that correspondence was medical treatment. But certainly, if one reads the reports as a whole, and this is the evidence presented by the appellant, it was a reasonable inference for the Arbitrator to draw that it was not until Dr Singh received the detailed letter of instruction from the appellant's solicitors that he was giving an opinion in light of those instructions.

His Honour dismissed ground (13) and he stated that if the decision is read as a whole, it is clear that by the time the Member describes Dr Bodel at p 6, he quite accurately and uncontroversially set out the doctor's presence in the matter and the fact that he was asked to provide a further opinion, which is of course different from obtaining a second opinion from a specialist on proposed treatment. Nothing turns on this minor mistake and the appellant has not argued how this has otherwise led the Member into appealable error.

His Honour rejected ground (14) and he stated, relevantly:

> 193. The duty of the Arbitrator is to weigh the medical evidence in its entirety. It is not a simple mechanical matter, as is asserted in this appeal point, that findings by radiologists must be accepted without qualification. In this matter there was a series of radiological examinations. Various specialists, Drs Singh, Rimmer, Dalton and Bodel, both treating and medicolegal, were, depending upon the doctor, supplied with some or all of these examinations. Each was eminently qualified within their specialty to comment upon the appellant's condition arising from not only a consideration of those radiological examinations but also their own consultation with the appellant.
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> 194. The benefit of having access to the radiological examinations, and indeed the other scans that the appellant underwent, would be to assure a decision maker that the individual doctor's opinion is given in a fair climate and can form a satisfactory basis for the decision maker to make findings. Additionally, I would note that the specialist radiologists were not positing an opinion. Rather they were describing their findings arising from their radiological investigation. Arising from a review of these investigations, as I have said, the various specialists provided their opinions.
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> 195. There is nothing in this approach which is indicative or revealing of any error in approach by the Arbitrator either in fact or law as alleged.

His Honour upheld ground (1) and he stated, relevantly:

> 199. All of the doctors involved in this matter found that the appellant suffered from various pathologies at different levels, C3/4, C5/6, and C6/7. There is a debate between the doctors as to which might be the more serious pathology. In terms of the evidence, there are three main opinions that had to be grappled with, namely the opinions of Drs Singh, Bodel and Rimmer. All three doctors had before them the results of the x-rays, MRIs and bone scans. However, Dr Singh had the added benefit of the knowledge of the relief experienced by the appellant after the C3/4 block injection. When Dr Bodel was made aware of this fact, his opinion changed. Dr Rimmer however did not have the benefit of this knowledge which was obviously of diagnostic importance to Drs Singh and Bodel. This issue, as I have found above, had to be grappled with by the Arbitrator. Reading the medical evidence, it is clear that the fact of the experience of this pain relief was germane to the ultimate opinions reached by Drs Singh and Bodel. It was therefore incumbent upon the Arbitrator to deal with this issue. As a result of this failure, the Arbitrator was not able to properly construe the medical opinion which was to the effect that the proposed surgery was reasonably necessary.

His Honour decided to revoke the COD and to redetermine the matter by applying the principles set out by Roche DP in *Diab v NRMA Limited*. He found that the proposed surgery was reasonably necessary as a result of the work injury and stated, relevantly:

> 210. I therefore find, on the basis of Dr Singh and Dr Bodel's opinions, that the proposed anterior cervical decompression and fusion is reasonably necessary as a result of the injury the appellant is deemed to have received on 10 October 2019. I accept the doctors' opinion that this is appropriate treatment for the appellant's condition. No issue was taken as to the proposed cost of the surgery, or the reasonableness of that cost in the amount claimed or as compared to other treatments. I am particularly taken by Dr Singh's opinion that "*[w]ithout surgery he can expect gradual deterioration of pain and function*". As Burke CCJ said in *Rose v Health Commission (NSW)*:
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> > It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgment and good sense, that it is so. That involves the Court in deciding, on the facts as it finds them, that the particular treatment is essential to, should be afforded to, and should not be forborne by, the worker.

211. In this case, the appellant has over a period of time undertaken a range of investigations and has closely consulted with his treating doctors. He has also had the benefit of a second opinion which was obtained at his request. He has, consistent with the advice of his surgeon, decided to proceed with the surgery which is recommended. This Commission, mindful of the remarks of Burke CCJ in Rose, is of the view that the appellant should be permitted to proceed with the recommended surgery.

Accordingly his Honour entered an award for the appellant with respect to the proposed surgery.

PIC – Medical Appeal Panel Decisions

Psychological injury – Whether Medical Assessor (MA) erred in assessing a impairments PIRS categories – Held: MAC revoked & a new MAC issued.

Moelker v State of New South Wales (Ambulance Service of New South Wales) [2021] NSWPICMP 202 – Member Perrignon, Dr J Parmegiani & Dr M Hong – 22/10/2021

On 17/06/2020 (deemed date) the appellant suffered a work-related psychological injury.

On 31/05/2021, Dr Andrews issued a MAC which assessed 7% WPI, including assessments of class 2 in 2 PIRS categories ("Self-care and personal hygiene" & "Concentration, persistence and pace").

The appellant appealed against the MAC under s 327(3)(d) *WIMA*. In relation to the category of self-care and personal hygiene, he argued that the Medical Assessor (MA) took into account an irrelevant matter, namely the degree to which he is able to look after his children, and he failed to take into account a relevant matter, namely his alcohol abuse. When this irrelevant factor is excluded, he satisfies the criteria for a class 3 assessment. In relation to the category of concentration, persistence and pace, he argued that the MA took into account an irrelevant matter, namely his ability to teach first aid, failed to give reasons why this was relevant and failed to take into account a relevant matter, namely the evidence that he is easily fatigued. When the irrelevant matter is excluded, he satisfies the criteria for a class 3 assessment. The Respondent opposed the appeal.

The ***Medical Panel (MP)*** referred to the decision of the Court of Appeal in *Ballas v Department of Education (State of NSW)* [2020] NSWCA 86, as authority for the proposition that which found that a MA may only take into account matters that are relevant to assessing that scale. It held that *Ballas* is authority for the proposition that where a behaviour or capability relates more directly to one scale than to another, it may only be taken into account in assessing the former.

The MP held that the category "*self-care and personal hygiene*" is directed to the appellant's ability to care for himself rather than to care for others and an ability to prepare meals for children and get them ready for school is irrelevant. It found that there was a demonstrable error and application of incorrect criteria by the MA such that the MAC must be set aside.

The MP also held that the MA erred by considering the appellant's ability to teach first aid in relation to the category of "*concentration, persistence and pace*". Accordingly, error was established and the MAC must be set aside.

The MP issued a fresh MAC, which maintained the assessments of class 2 in the disputed categories, although for different reasons, and the assessment of 7% WPI.

Injury at work in 2010 resulted in an award under ss 66 & 67 WCA – Further s 66 claim for alleged deterioration - choice of Medical Assessor (MA) - diagnosis by MA different to injury as pleaded - assessment by analogy - MAC confirmed.

Lee v Bunnings Group Limited [2021] NSWPICMP 203 – Member McDonald, Dr M Burns & A/Prof C Grainge – 29/10/2021

On 2/06/2010, the appellant was moving bags of "*Weed and Feed*" at work when she noticed that one of the bags had split and gave off a strong odour. She quickly began to cough and complained of a constricted feeling in her throat and was taken to hospital. She returned to work the next day, but was exposed to another substance and suffered a throat irritation, a severe cough and her tongue began to swell. She ceased work and did not return to work.

The appellant had previously served as a police officer and ceased work on medical grounds (PTSD).

On 28/11/2011, Dr Clarke issued a MAC which assessed 10% WPI (respiratory system) and the appellant received compensation under ss 66 and 67 *WCA* based on the MAC.

The appellant alleged a deterioration in that she now suffers from Multiple Chemical Sensitivity Syndrome (MCS) and she claimed further compensation under s 66 *WCA* for 25% WPI, less the previous award of 10% WPI.

During a teleconference on 7/09/2020, an Arbitrator referred to dispute to Dr Burns for assessment. However, Dr Burns felt that he lacked the expertise to assess the dispute and the matter was then referred to Dr Haber, but he also considered that he was not the correct specialist to assess the dispute. The matter was then referred to Dr Kaufman.

However, Dr Kaufman was qualified by the appellant in her previous claim. As there were no other available specialists, the respondent did not oppose the referral to Dr Kaufman.

On 30/03/2021, Dr Kaufman issued a MAC, which assessed 10% WPI, but he applied a deduction of 1/10 under s 323 *WIMA* due to the appellant's psychological condition and reduced his assessment to 9% WPI.

The appellant appealed against the MAC under ss 327(3)(c) and (d) *WIMA*. The respondent opposed the appeal.

Following a preliminary review, the MP determined the appeal on the papers and stated that it was not necessary to re-examine the appellant. The MP stated that the grounds of appeal were quite narrow, perhaps because of the appellant's foreshadowed application for judicial review of the decision made by the Registrar's delegate to refer to dispute to Dr Kaufman. She disputes the process by which the matter was referred to Dr Kaufman and argued that his comment that all parties had agreed to the referral was a sufficient demonstrable error to overturn the MAC. The only other alleged error was that Dr Kaufman came to his own diagnosis which was inconsistent with the referral. Notably, no ground was raised with respect to the 1/10 deduction under s 323 *WIMA*.

The MP stated that the referral to the Dr Kaufman reflected an agreement by the parties at a teleconference. The Arbitrator declined to assess WPI and the MA was asked to assess WPU by reference to the respiratory system. The agreement of the parties and consequent referral did not provide any further guidance to Dr Kaufman and there was no determination regarding the nature of the injury to the respiratory system. The assessment was conducted by videoconference and the doctor MA set out his diagnosis as follows:

> Ms Lee does not have asthma and nor are the features she describes that of multiple chemical sensitivity syndrome. There is a heightened sensitivity or exaggerated response to irritants at the level of the larynx. This condition has a name: inducible laryngeal obstruction or vocal cord dysfunction. It occurs more frequently in people with anxiety disorders and thus, may be psychological in nature. Although an alteration in response to irritants may have a physiological basis….
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> This is a very difficult assessment to make and I am calling upon my qualifications and current practice experience as a Respiratory Physician and an Allergist, and a General Physician. Ms Lee describes ongoing symptoms that all primarily relate to reactivity of the upper airways (the laryngeal structure) rather than the lungs. This is an area of anatomy that is addressed by respiratory physicians and allergists as well as Ear, Nose and Throat doctors. The nature and quality of symptoms described by Ms Lee are that there is a heightened response to a wide variety of inhaled substances that trigger a cough and then very likely cause narrowing of the larynx resulting in reduction in inspiratory airflow, rather than the expiratory airflow reduction that is generally the hallmark of asthma. This condition which is known as inducible laryngeal obstruction and also as vocal cord dysfunction syndrome is recognised to be in many sufferers set off by irritants and also emotional stress. It is more frequently identified in those people who have an anxiety disorder.

Dr Kaufman noted the appellant's history of PTSD and noted that there was no one reference in the various GPs' notes to an episode of asthma, which is consistent with the diagnosis not being asthma. He also stated, relevantly:

> The pattern of symptoms is not what he sees in patients who would be classified as having Multiple Chemical Sensitivity Syndrome. Although a large variety of chemicals are considered to trigger the upper respiratory tract irritability, they do not here trigger the pattern of symptoms usually associated with the label, multiple chemical sensitivity syndrome. This itself is a controversial condition and considered by some to have a psychological contribution.
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> On the 9th April 2012, the general practitioner notes that Ms Lee was smoking 20 cigarettes per day. There were treatments implemented to cease smoking. This was ultimately achieved. Nonetheless, the fact that the many chemicals that are found in tobacco smoke did not induce the symptoms from which Ms Lee suffers does add to the impression that there is a psychological factor underlying the reactivity to chemicals.

Dr Kaufman noted that the condition of "*inducible laryngeal obstruction*" is not addressed in the Guidelines. He referred to para 1.23 and stated:

> I interpret this to mean that I can compare the upper airway condition to asthma which is a lower airway condition where in both there is obstruction to airflow. The analogous form of asthma is where there is intermittent impairment of airflow. This gives rise to normal measurements of airway function, i.e. FEV1 and FVC and their ratio but with the need for intermittent medication to relieve symptoms of asthma. In the current situation, the airflow limitation is in the upper airways with normal lung function at other times. In referring to Table 5-9 on page 104 of AMAS, a score of 1 is given for asthma severity where measurements of airway function are normal and minimum medication includes occasional but not daily bronchodilator. This is the pattern that is applicable for Ms Lee. In Table 5-10 which provides for impairment rating for asthma in AMAS, Page 104 an asthma score of 1-5 gives an impairment of the whole person of 10-25%. As the score of 1 is at the lower end of that range, this would be commensurate to an impairment of 10%.
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> It is impossible to be certain just how much of a contribution psychological factors are having in bringing about the symptoms that Ms Lee describes and how much might be due to a heightened responsiveness to irritant chemicals by nerve fibres in the laryngeal region, As the extent of the psychological contribution is difficult to determine, I assessed the deductible portion as 1/10 of the 10% whole body impairment. This gives an impairment of 9%.

In commenting on the other medical opinions, Dr Kaufman stated:

> In my own report from the 9th March 2011, I gave reasons why I did not believe the condition was multiple chemical sensitivity syndrome. I had reservations about a diagnosis of reactive airways dysfunction syndrome (a form of occupational asthma) but seemed the closest fit. Dr Clark agreed with this in his report. Since that time, there has never been documentation of airflow limitation. The notes from multiple general practitioners not once refer to an episode of asthma. Other respiratory physician reports also discount reactive airways dysfunction syndrome persisting to the present (reports of Professor Young).
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> Dr Garcia [sic], an immunologist considered the possibility of multiple chemical sensitivity syndrome but was also of the view that psychological factors might be underlying the reported symptoms.

The MP held that Dr Kaufman properly assessed permanent impairment by analogy and explained his reasoning. It noted that the other IME's who made higher assessments did so without referring to the Guidelines or AMA 5 and that Dr Slezak (the appellant's IME) assessed 25% WPI based on the fact that the condition interferes with her day to day life and precluded a return to employment. It was an estimate. Similarly, Professor Young (the respondent's IME) provided an estimate without forming a concluded view and stated that whether the assessment is permanent is contingent upon further assessment and possible treatment by an immunologist and/or psychiatrist.

The MP held that Dr Kaufman's method of assessment was appropriate. He determined that the analogous condition was asthma with intermittent impairment of airflow and he assessed score 1 under Table 5-10, which provides a range of 10% to 25% WPI for asthma with a score from 1 to 5. It agreed that a score 1 would result in an assessment at the lower end of the range and that the assessment of 10% WPI was an appropriate exercise of the MA's clinical judgment.

Accordingly, the MP confirmed the MAC.

PIC – Member Decisions

Applicant alleged that he was a full-time live-in caretaker on a rural property – Respondent disputed that there was a contract of service and that the injury arose out of or in the course of employment – Applicant could not remember what happened to him on the night he was injured, but 2.5 years later he asserted that he was dealing with work issues - Held: There was a contract of service, but the Applicant's reconstruction was speculation and he did not discharge his onus of proof – Award for the respondent entered

Mooney v White [2021] NSWPIC 423 – Member Batchelor – 17/08/2021

On 10/01/2007, the applicant injured his right leg when he fell off the balcony of a house on a property owned by the respondent. He alleged that he was engaged by the respondent as a live-in caretaker/house sitter and that he was an employee at the time of his injury. He claimed compensation under s 66 *WCA* for 45% WPI.

The Respondent disputed that the applicant was a worker and asserted that the arrangement between them was an informal one, under which the applicant was expected to perform some work around the property and small chores for approximately 4 hours per day 5 days per week in return for permission to live rent-free in the house. In the alternative, he asserted that if there was a contract of service, the injury was not received in the course of employment.

Member Batchelor identified the issues as: (1) whether the Applicant was a worked as defined in s 4 *WIMA*; and (2) whether the injury arise out of or in the course of employment. After discussing the evidence and the parties' submissions in detail, he held that there was a contract of service between the parties.

The Member expressed concern about the reliability of the applicant's evidence, and the fact that his theory as to why he was on the balcony just before his fall on 10/01/2007 emerged so long after the event. It appears that it was first mentioned by him on 9/11/2009, which is two years and ten months after his injury. He stated:

> 72. In reality, the applicant does not know why he went out onto the balcony in the period immediately before he fell therefrom. He speculates as to the reason he was there. Brian Mooney was a heavy smoker and I suspect that the reason he was there is that put forward by the respondent, that is that he went out to have a cigarette. I have found that the conversation between Mr White and Brian Mooney, in which the suggestion was made that the reason the applicant was on the balcony was that he went out to have a cigarette, took place. I am not required to make a finding as to why Brian Mooney was on the balcony at the time, but I do not accept that the applicant has discharged the onus of proof on him to show that it was to do with cattle on the property.
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> 73. In *Onassis and Calogeropoulos v Vergottis* Lord Pearce said of documentary evidence:
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> > It is a truism, often used in accident cases, that with every day that passes the memory becomes fainter and the imagination becomes more active. For that reason a witness, however honest, rarely persuades a Judge that his present recollection is preferable to that which was taken down in writing immediately after the accident occurred. Therefore, contemporary documents are always of the utmost importance.

74. The same observation can be made of the theory first put forward by the applicant in November 2009, as to the reason he was on the balcony immediately before he fell on 10 January 2007. Whilst contemporary documents are of the utmost importance, similarly what the applicant recalled, or was not able to recall, contemporaneously after the fall on 10 January 2007 as to why he was on the balcony, is of the utmost importance. Brian Mooney said to Colin Freeman, when he visited him in Taree (which is where Manning Base Hospital is situated) with Robert Allport, that he did not know what happened about the circumstances of the fall. The applicant freely acknowledges this. What he thereafter postulates as the reason for him being on the balcony is no more than speculation.

75. The decision-maker of the Commission must, pursuant to rule 73 of the Rules, have regard to evidence that is logical and probative and not accept evidence based on speculation or unsubstantiated assumptions. In my view the applicant's evidence as to why he was on the balcony on 10 January 2007 immediately before he fell is speculation. It is also based on an unsubstantiated assumption that there were cattle attempting to enter the area around the dwelling on the property at around 10.00 pm on 10 January 2007.

76. I accept the respondent's submission that the injury sustained by the applicant when he fell from the balcony sometime after 10.00 pm on 10 January 2007 was not an injury arising out of or in the course of his employment with the respondent.

Accordingly, the Member entered an award for the respondent.

PIC – President's Delegate Decisions

Work capacity dispute - definition of suitable employment in s 32A WCA - applicant injured in bakery - suitable employment identified as role as a bank branch manager - applicant had prior work experience an assistant bank manager and had transferrable skills, experience and qualifications – WCD upheld

D'Mello v Coles Supermarkets Australia Pty Ltd [2021] NSWPIC 426 – Delegate McAdam – 8/10/2021

The worker migrated to Australia in 2005 and began working for Bakers Delight in the production team. He then c worked with ANZ for a number of years and in 2017, he resumed working with Bakers Delight in the production of bread and then worked at Coles as the manager of its bakery department.

In June 2018, the worker injured a shoulder at work. He resumed suitable duties in customer service and returned to pre-injury duties in January 2019, but suffered an aggravation of that injury and a consequential condition in his other shoulder due to overuse.

On 20/05/2021, the respondent issued a WCD, which identified the roles of bank and branch manager, office manager and customer service manager as suitable employment options, and reduced weekly payments to NIL effective from 29/08/2021. The worker disputed the WCD.

President's Delegate McAdam identified the issues for determination as being: (1) the period for which the worker is entitled to weekly payments under s 37 *WCA*; and (2) whether the employment options identified in the WCD are suitable employment within the definition of s 32A *WCA*.

The Delegate noted that the worker was certified as having capacity for some type of employment for 7.6 hours per day, 5 days per week, with certain physical restrictions, for the period from 16/07/2021 to 13/08/2021 and that from 12/08/2021 to 10/09/2021, he was certified as having work capacity for 7.5 hours per day, 5 days per week. He also noted that the NTD approved the identified options as being suitable employment for the worker.

In relation to issue (1), the worker argued that the s 37 period ceases on 21/02/2022 and that during the period from 10/07/2020 to 28/09/2020, he had resumed his pre-injury duties and there was no total or partial incapacity for work as required by s 33 *WCA*, and therefore this period should not be included in the aggregate entitlement period under s 37 *WCA*. He also stated that during the period from 18/09/2020 to 28/09/2020, while he was certified fit for work for 35 hours per week, he was actually working 40 hours per week.

The worker also argued that while he worked in the banking sector for a number of years, he has not worked in that industry since he left ANZ in June 2015 and he has not had an office-based role since then and he has not been able to maintain or accumulate the skills required for any of the identified roles.

The Delegate found for the Respondent in relation to issue (1) and he held that the s 37 period ended on/around 1/10/2021.

In relation to issue (2), the Delegate noted that the dispute was focussed entirely on the worker's age, education, skills and work experience. He found that the worker has had extensive experience in the banking industry and he did not accept the worker's argument that his experience was out of date for reasons that included: (1) He had not explained how the industry has changed so dramatically that his experience would no longer be relevant and in the context of a 25year plus working career, the period of 6 years is not overly significant; (2) He has been performing managerial and supervisory functions with the respondent for a number of years and this experience is immediately relevant and transferrable to the identified roles; (3) He has specific experience at the managerial/supervisory level at ANZ bank; (4) The list of transferrable skills contained in the vocational assessment report is extensive; and (5) The worker's age is not an impediment or a relevant consideration as he is not being expected to retrain in an entirely new industry or skill and enter the workforce with no previous relevant experience. Also, the worker is not close to retirement age in real terms.

Accordingly, the Delegate held that the identified role of bank/branch manager is suitable employment within the definition of s 32A *WCA* and that the worker is not entitled to weekly payments during the period claimed. He entered an award for the respondent.