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Bulletin of the Workers Compensation Independent Review Office (WIRO)

CASE REVIEWS

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.

Decisions reported in this issue:

1. Fuller v Avichem Pty Ltd t/as Adkins Building & Hardware [2019] NSWCA 305
2. IAG Limited t/as NRMA Insurance v McBlane [2019] NSWSC 1789
3. Broadspectrum (Australia) Pty Ltd v Wills [2019] NSWSC 1797
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Court of Appeal Decisions

Damages – residual earning capacity – whether a discount greater than 15% for vicissitudes is warranted – whether clinical psychologist is sufficiently qualified to give expert evidence about residual earning capacity

Fuller v Avichem Pty Ltd t/as Adkins Building & Hardware [2019] NSWCA 305 – Macfarlan, Payne and White JJA – 13 December 2019

On 11 August 2009, the appellant suffered injury (including injuries to his back and left shoulder) at work.

The appellant claimed damages for alleged breach of statutory duty and ***Scotting DCJ*** awarded him damages totalling $421,652 for past and future economic loss. His Honour relied upon an earning capacity assessment by Ms Own, clinical psychologist, which identified roles that she said the appellant would be able to undertake, including customer service call centre roles.

The appellant raised the following issues: (1) whether the primary judge erred in finding that he had a residual earning capacity of 8 hours per week; whether Ms Owen was

sufficiently qualified to give expert evidence on the matters with which her report dealt; (3) whether the primary judge erred in determining the percentage discount for vicissitudes at 25 per cent; and (4) whether the primary judge erred in failing to award, and/or consider, damages for a lost opportunity to qualify for long service leave.

The Court (Macfarlan, Payne and White JJA) upheld the appeal and held, relevantly:

> In relation to Question (1), the respondent did not discharge its onus of demonstrating the likelihood of the appellant obtaining employment in the future. The primary judge should have assessed damages on the basis that he will remain totally incapacitated for work for the remainder of his working life and that he therefore has no residual earning capacity: [60]; [97]-[98]; [107]. *Dal v Chol* [2018] NSWCA 219; *Nominal Defendant v Livaja* [2011] NSWCA 121, referred to.
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> In relation to Question (2), Payne and White JJA held that the primary judge did not err in admitting the evidence of Ms Owen. Ms Owen demonstrated relevant specialised knowledge in vocational rehabilitation and the safe return to work of injured workers acquired through her training, study or experience in those fields over many years: [89], [107]. *Dasreef Pty Limited v Hawchar* (2011) 243 CLR 588; [2011] HCA 21, referred to.
>
> However, Macfarlan JA dissented and held that Ms Owen did not have the expertise to enable her to express opinions as to what specific jobs were available that the appellant would or would not be able to undertake: [41]-[42].
>
> In relation to Question (3), in New South Wales, 15 per cent is the conventional allowance for vicissitudes. This was not a case where a greater than usual discount for vicissitudes should have been allowed: [63], [105], [107]. *FAI Allianz Insurance Ltd v Lang* [2004] NSWCA 413; *State of New South Wales v Moss* (2000) 54 NSWLR 536; [2000] NSWCA 133; *Wynn v NSW Insurance Ministerial Corporation* (1995) 184 CLR 485; [1995] HCA 53; *Moran v McMahon* (1985) 3 NSWLR 700, referred to.
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> In relation to Question (4), the primary judge's finding that, but for the accident, the appellant would have remained in the respondent's employment until his retirement supported his claim in respect of loss of the value of future long service leave entitlements. This indicated a probability that he would have satisfied the requirements under the *Long Service Leave Act* to qualify for entitlements to Long Service Leave. [72], [106], [107].

Supreme Court of NSW Decisions

Jurisdictional error – reasons inadequate

IAG Limited t/as NRMA Insurance v McBlane [2019] NSWSC 1789 – Lonergan J – 13 December 2019

The plaintiff (a CTP insurer) sought judicial review of a decision of a SIRA claims assessor dated 23 April 2019, who assessed damages of $160,326.65 for injuries sustained in a MVA on 21 October 2015, including a buffer of $85,000 for loss of future earning capacity (inclusive of loss of superannuation). The plaintiff alleged jurisdictional errors and/or errors of law on the face of the record, or constructive failure to exercise statutory power or jurisdiction, namely:

> (1) The assessor failed to make findings and/or to give reasons as to what injuries he found were caused by the accident, that were then said to give rise to the losses that were assessed by the claims assessor. The making of findings and the giving of reasons was part of the claims assessor's duty and statutory function as a claims assessor. Giving reasons as to findings on material questions of fact are also specifically required by clause 18.4 of the *SIRA Claims Assessment Guidelines* ("*the Guidelines*"), guidelines which were made pursuant to ss 69 (1) and 106 of *the Act*;

(2) In making his decision about future economic loss, the claims assessor erred in law in that he: (i) Failed to state his own relevant assumptions pursuant to s 126 of *the Act* as he was required to do that led to the award of $85,000. (ii) Failed to set out proper or lawful reasons as he was required to do pursuant to s 94 (5) of *the Act* and cl 18.4 of *the Guidelines*; and

(3) The decision was vitiated by legal unreasonableness – *Minister for Immigration v Li* (2013) 249 CLR 332; [2013] HCA 18 – in that:

(i) No sensible claims assessor acting with due appreciation of his responsibilities would have given an award without addressing key issues such as the injuries sustained by the claimant, issues pertaining to economic loss including matters such as what the claimant's earnings were prior to the accident and/or what her earning capacity would have been, were it not for the accident, and the claimant's age and expectation of working life.

(ii) The claims assessor reasoned illogically or irrationally as set out above.

(iii) The decision lacks evident and intelligible justification as set out above.

Lonergan J noted a significant dispute regarding the defendant's entitlement to damages. The plaintiff argued that the assessor's reasons were bereft of necessary findings and the s 126 duties were not fulfilled and while s 94 (5) requires a "*brief statem*ent" setting out an assessor's reasons for the assessment, it still requires reasoning and key findings to be articulated, but they were not. The defendant conceded that the reasons were imperfect, but argued that the necessary findings could be "*sticky-taped*" together.

After referring to ss 94 and 126 of *MACA,* Her Honour held that it was self-evident that findings on material questions of fact, mention of the applicable law and an articulation of the reasoning processes that led to the conclusions reached would clearly be essential matters to comprise a brief statement of reasons as required by s 94 (5). As Leeming JA observed in *Zahed v IAG Limited trading as NRMA Insurance and Ors* (2016) 75 MVR 1:

> [9] … the reasons need not be long. Indeed there will be many cases, of which I suspect this is one, where a single sentence would suffice…

Her Honour held that the salient parts of Leeming JA's judgment of in *Zahed* "*articulates with clarity the area for debate between counsel in the circumstances that have arisen in this case*":

> [4]…Plainly enough, there may be a tension between the obligation to explain and the obligation to be concise. That is a familiar tension (for example, pleadings must "contain only a summary of the material facts on which the party relies", and be "as brief as the nature of the case allows": see now UCPR Pt 14 rr 14.7 and 14.8). The resolution of the competing obligations imposed by s 94(5) and cl 18.4.3 ought not to result in an unduly demanding burden of providing reasons. It is to be borne in mind that the objects of the Guidelines are "to provide a timely, fair and cost effective system for the assessment of claims" and "to assess claims and disputes fairly and according to the substantial merits of the application with as little formality and technicality as is practicable and minimising the cost to the parties" (cl 1.14), and the obligation to set out the reasoning process is to be construed accordingly. The obligation thereby imposed is less than that imposed on courts: see eg *Allianz Australia Insurance Ltd v Kerr* [2012] NSWCA 13; 83 NSWLR 302 at [53]-[59]; *Pham v NRMA Insurance Ltd* [2014] NSWCA 22; 66 MVR 152 at [29]-[31]. Further, as Basten JA's judgment in *Kerr* indicates, by reference to authority, the nature of the Assessor's task may mean that aspects are insusceptible of any detailed articulation of reasons…

[6]…If the only complaint were the failure to state expressly that the 6.76 hours was derived from the certificate of Assessor Davidson, then there would in my opinion be no breach of the obligations imposed on the Assessor. Although it is undesirable for the statement of reasons to leave important matters to inference, doing so does not necessarily breach the obligation to set out the Assessor's reasons. The question is whether the reasoning process can be discerned, reading the reasons as a whole and applying a "*beneficial construction*" to which the High Court referred in *Minister for Immigration and Ethnic Affairs v Wu Shan Liang* (1996) 185 CLR 259 at 271-272. At least where a gap may be filled as a matter of necessary inference on a fair reading of the reasons, I would consider that the obligation to set out the reasons has been discharged.

[7] …However, the Assessor found that 6.76 hours per week of assistance was required until the date of assessment and until some stage in the future. That was inconsistent with the certificate of Assessor Davidson, who had found that most of the heads of domestic assistance ceased to be necessary or reasonable after 8 November 2011. It was also inconsistent with the views of Dr Maniam (who was of the view that the need would extend for the whole of Ms Zahed's lifetime). What then was the reasoning process which led the Assessor to reject the opinions of all of the practitioners who gave evidence on this point and reach a different conclusion?

[8]…The short point in this appeal is that the certificate discloses no reasoning process on that critical integer in the calculation of this head of damages at all.

[9]…I would not regard it as necessary for the Assessor to explain why he disagreed with aspects of each of the practitioners' opinions. However, it is necessary for the statement of reasons to explain why the 6.76 hours per week for past gratuitous care was regarded by him to be necessary to the date of the assessment. The reasons need not be long. Indeed, there will be many cases, of which I suspect this is one, where a single sentence would suffice. But to say merely that all of the conflicting evidence was taken into account is, in the facts of this case, insufficient. The matter may be tested against the parties' rights of review: how are the parties to know whether the reasoning is affected by judicially reviewable error of law?

Regarding s 126 and the inadequacy of reasons, her Honour noted that Basten JA addressed this specifically in *Allianz Australia Limited v Kerr* (2012) 83 NSWLR 302 at [31] His Honour referred to *Nominal Defendant v Livaja* [2011] NSWCA 121, where the court said that the assumptions or events upon which a baseline may commonly be calculated include:(a) identification of the skills, training and experience of the plaintiff, as at the date of the accident; (b) the work he or she was undertaking immediately prior to the accident; (c) the likelihood that he or she would have continued in such employment, but for the accident; (d) the possibility that he or she might have obtained promotion or other benefits, but for the accident; (e) the age to which he or she was likely to have worked in that employment, and (f) the possibility that the employment would not have been continuous.

Her Honour stated that a distinction should be made in cases that deal with the detailed calculation of future economic loss, as opposed to "*buffer*" cases: *Allianz Australia Insurance Limited v Sprod* [2012] NSWCA 281 at [30] to [33] per Barrett JA:

[30]…In a true "*buffer*" case, the obligations imposed by s 126 upon the assessor may be discharged by much more generalised statements: see *Allianz Australia Insurance Ltd v Kerr* (above) at [69] per Macfarlan JA. But there will still be, of necessity, some assumptions. Assumptions as to life expectancy and likely remainder of working life are examples, even if circumstances mean that the assumptions are necessarily somewhat impressionistic. But if that is the quality of the relevant assumption, it is still possible for it to be stated, if only in very general terms, for example, that remaining working life has been assumed to be a minimum

> of five years and a maximum of twenty years. That, while it would do little to elucidate any basis of calculation, would serve to accentuate one aspect of the uncertainty that formed the very basis for resort to the evaluative approach of "*buffer*".

Her Honour held that the assessor's calculation clearly showed that the he adopted an expected residue of working life of 18.3 years and a discount for vicissitudes of 15% (hence the 0.85 multiplier)., but there was no explicit explanation of why a residual working life of 18.3 years was chosen or, more precisely, what assumption was made in that respect, and there is no reference to the assumption that gave rise to the allowance of 15% for vicissitudes. Those matters may not call for particular elaboration or explanation and a brief statement of what might seem to be reasonably obvious may well suffice. The decision of Fagan J in *IAG Limited v Priestly* [2019] NSWSC 1185 is of guidance, where he was critical of the assessor's failure to make necessary determinations to understand the "*buffer*" awarded for future loss of earnings:

> [24]…The assessor's decision to award a buffer future economic loss appears at [86], devoid of explanation. The assessor stated that he had taken into account a number of variables, which he did not quantify, in his "*assessment of a buffer for her future loss of income which I assess to be $400,000*". He said, "*Such sum is inclusive of vicissitudes and superannuation.*"
>
> [25]…Although the assessor's findings extracted above amounted to a conclusion that, but for the accident, the claimant would have worked full-time for a further 40 years, he did not determine which was the most likely of her career alternatives (supervisor of a childcare centre or further study leading to a primary school teaching role) or what her weekly income would likely have been from whichever of those alternatives was the most probable.
>
> [26]…Further, the assessor did not make any finding as to what the claimant's weekly hours would be reduced to as a result of her impairment. Nor did he determine whether the overall length of her working life would be reduced. At [84] he noted a submission – it is not clear from whom - that the plaintiff would be likely to work for only 20 hours per week. The assessor does not say whether he accepted that this was likely or whether he thought it more probable that she would work four days per week as she had done for 7 months up to February 2017.

Her Honour held that the reasons do not contain a finding about what parts of the defendant's body were impaired and the assessment includes vague references that are insufficient to overcome this problem. The reasons are "*fatally inadequate*" and the defendant's valiant attempts to "*sticky-tape*" together sufficient findings only served to highlight their inadequacy. Accordingly, she set aside the assessor's decision and remitted the matter for determination by a different claims assessor, according to law.

Judicial review – whether it was open to the MAP to refuse to re-examine the worker in circumstances where the AMS noted disparities in the history given and effort on examination – whether the MAP was obliged to receive additional reports served by the plaintiff after the decision under review – Alleged denial of procedural fairness

Kitanoski v JB Metropolitan Distributors Pty Limited [2019] NSWSC 1802 – Adamson J – 16 December 2019

On 10 May 2014, the plaintiff was injured at work when a box fell from a shelf. He claimed compensation and the insurer accepted the claim. He has not worked since then.

On 12 August 2015, a MAC assessed 0% WPI and on appeal, a MAP confirmed the MAC on 12 May 2015.

On 7 December 2017, the plaintiff made a further claim for WPI against the employer, for 15% WPI (cervical spine), 10% WPI (lumbar spine), 8% WPI (vestibular injury), 7% WPI (hypertension), 4% WPI (upper digestive system) and 4% WPI (lower digestive system). However, the employer disputed the claim and the dispute was referred to Dr Truskett (lead AMS and to Dr Ackroyd AND Dr Williams (non-lead AMS'). On 27 November 2018, a MAC certified 7% WPI (cardiovascular impairment). Dr Truskett and Dr Williams each assessed 0% WPI.

On 24 December 2018, the plaintiff appealed against the MAC under ss 327 (3) (a), (c) and (d) *WIMA.* He requested a re-examination by an AMS-member of the MAP and sought to rely upon additional evidence. However, the employer opposed the appeal.

On 15 March 2019, Delegate McGrowdie was satisfied that a ground of appeal under s 327 (3) (d) *WIMA* was made out and he referred the matter to a MAP. However, he did not identify the error in his decision.

On 24 May 2019, the MAP dismissed the appeal and gave reasons for its decision. It decided that it was not necessary for the plaintiff to be re-examined because there was sufficient evidence before it to enable it to determine the appeal. In relation to the application to adduce fresh evidence, the MAP referred to the test in s 328 (3). It held that the plaintiff did not address why further evidence from his qualified specialists could not have been obtained before the referral and that this evidence simply sought to cavil with the findings of the AMS and did not satisfy s 328 (3).

The MAP rejected the argument that Dr Truskett had not complied with the Guidelines and held that it was satisfied that he conducted a definitive physical examination and found that the worker's presentation, and particularly his widespread loss of power and sensory impairment in the whole left leg (which was not in any dermatomal distribution), did not satisfy the criteria for a finding other than that of DRE 1 in respect of both the cervical and lumbar spines. It also rejected the challenge to Dr Williams' MAC, which was based upon his assessment on the day of the examination.

Adamson J noted that the summons did not identify separate grounds, but the narrative contains allegations that she proposed to consider as grounds, as follows:

> *(1) Refusal to examine the plaintiff* - The plaintiff argued that the MAP failed to accord him procedural fairness by refusing to re-examine him and by failing to give sufficient reasons for its refusal. He also argued that it was not open to the MAP to refuse to re-examine him in circumstances where his credit was in issue.
>
> *(2) Refusal to receive additional reports* - The plaintiff argued that it was not open to the MAP to refuse to receive the additional reports because they could not have been obtained before the MAC as they dealt with the matters raised by the AMS. He also argued that these constituted additional relevant information within the meaning of s 327 (3) (b) *WIMA* and that its refusal amounted to procedural unfairness.
>
> *(3) Refusal to consider the plaintiff's statutory declaration* - The plaintiff argued that it was not open to the MAP to refuse to consider his statutory declaration dated 22 December 2018 and its refusal amounted to procedural unfairness.

In relation to these grounds, her Honour held that a MAP is required to undertake a review of the AMS' medical assessment and its role is not to undertake a fresh assessment unless it has decided to revoke the MAC and considers that it is obliged to do so to enable it to issue a new MAC. There is no entitlement on the part of the plaintiff to re-examination by the MAP.

Her Honour rejected the plaintiff's assertion that the MAP was obliged to examine him because the AMS formed an adverse view of his credit and she stated:

63. …What the AMS was concerned to establish was the reliability of the plaintiff in terms of the history given, the symptoms described and the conduct on examination. This is a different process than the assessment of credibility in a courtroom: see the discussion of credibility in *Onassis v Vergiottis* [1968] 2 Lloyd's Rep 403 at 431 (Lord Pearce). Where a medical expert, such as an AMS, notes a disparity between the history given and a known fact, or the symptoms described and known medical conditions or the conduct on examination and the AMS' knowledge of medical science, the medical expert is not, at least for the purposes of assessing *physical* impairment, concerned (as a court might be) with the question whether a claimant is, for example, lying for financial gain or whether there is a functional overlay or another psychiatric explanation for the disparity.

64. In so far as the AMS assessed the plaintiff's credit, its assessment was based on two matters: first, a disparity between the history the plaintiff gave and the objective facts as established by the documents which had been placed before the AMS; and second, a disparity between the symptoms described by the plaintiff and any known organic cause. The first matter was a matter of record. The second matter was one which called for medical expertise. Each of these matters was germane to the assessment of impairment since it was important to determine whether the plaintiff was a reliable historian and whether the findings on examination reflected an organic cause. This task was pre-eminently one for the AMS, as a medical expert. The Panel did not need to examine the plaintiff to review the AMS's comparison between his stated symptoms and any known organic cause since this was a matter within its medical expertise. Nor did it need to have regard to the plaintiff's statement since the fact of the disparity between findings on examination and known organic cause was not something that could be explained by the plaintiff himself.

65. There was no denial of procedural fairness since the plaintiff was given an opportunity by the Panel to make submissions about any errors made by the AMS. The plaintiff made detailed submissions to the Panel about this matter which, as is apparent from the Panel's reasons, were considered by the Panel.

In relation to ground (4), whether an examination was required for the MAP to form a view about the percentage WPI of the lumbar spine, her Honour noted that the MAP held that Dr Truskett's failure to measure his calf circumference in order to determine muscle wasting, was not of significance in terms of his examination of the lower limbs as a whole. She stated that the MAP addressed the plaintiff's submissions on muscle wasting and was entitled to reject them and no practical injustice was occasioned by its to not examine the plaintiff. Its reasons amply explained why it took that approach. In any event, calf measurement is not mandated by *the Guidelines* in the absence of any finding of radiculopathy and there was no such finding. Therefore, there was no error by Dr Truskett.

In relation to ground *(5), whether the MAP was obliged to examine the plaintiff to repeat the Hallpike test,* her Honour held that the obligation to keep testing until a positive finding is made would appear to be inconsistent with the protocol in *the Act* for assessing permanent impairment and for reviews to appeal panels of such impairments. While s 329 empowers the Registrar to refer a claimant for further assessment as an alternative to a appeal, *the Act* does not contemplate that an AMS will be on call to assess exacerbations if and when they arise. Further, the MAP was in a position to address the plaintiff's detailed submissions regarding the different findings made over time when the Hallpike test was administered.

In relation to ground *(6), the alleged failure to consider the further evidence,* her Honour stated, relevantly:

> 73. The reason for the limitation on material that can be placed before a Panel which is conducting a review of the medical assessment by an AMS is that the Panel is reviewing the assessment of the AMS and not conducting a fresh assessment (subject to the matters referred to above). It is plain from the Panel's reasons that the Panel considered each of the Additional Reports in deciding whether to admit them as part of its review. As its reasons reveal, the Panel's view was that the authors of the Additional Reports were merely providing commentary on the findings and reasons of the AMS. The Panel is an expert body which is well-placed to review the AMS, another expert or group of experts. A new report from a doctor which post-dates the assessment conducted by the AMS does not thereby constitute fresh evidence. Its contents must be examined to ascertain whether it is actually fresh or whether it merely rehashes old arguments or cloaks submissions in a new form. It was open to the Panel to consider that the Additional Reports fell into the latter category. The Panel's refusal to admit the Additional Reports (although it considered them and gave reasons for its decision not to admit them) does not amount to an error of law. There was no denial of procedural fairness.

Accordingly, her Honour dismissed the summons and ordered costs against the plaintiff.

Judicial review – pre-existing psychiatric conditions that were being treated and were asymptomatic – work caused psychological injury and WPI – MAP applied a deductible of 20% for pre-existing impairment – MAP did not err by not taking account of the fact of treatment – adequacy of reasons

Broadspectrum (Australia) Pty Ltd v Wills [2019] NSWSC 1797 – Meagher J – 17 December 2019

This matter has a lengthy prior history and was reported in Bulletins numbered 22 and 29, respectively. However, by way of summary, in previous judicial review proceedings Harrison AsJ set aside a decision of the first MAP due to jurisdictional error and remitted the matter to the WCC for re-assessment by an AMS.

On 25 September 2018, A/Professor Robertson issued a MAC, which assessed 22% WPI, but he applied a deductible of 1/10 under s 323 *WIMA*. The insurer appealed under ss 327 (3) (c) and (d) WIMA and the Registrar referred the appeal to a different MAP, which conducted a preliminary review and decided to determine the appeal on the papers.

The MAP held that the AMS identified pre-existing conditions (as defined by s 323 (1) *WIMA*) and that s 323 (2) *WIMA* did not apply because he canvassed the medical evidence in a comprehensive and accurate summary. The authorities require that all the evidence be considered in the assessment of the appropriate deduction pursuant to s 323. It is erroneous to rely on assumption or hypothesis to formulate such an assessment. It applied a deductible of 20% under s 323 WIMA, . revoked the MAC and issued a fresh MAC, which assessed 18% WPI (rounded) because of the injury.

The plaintiff applied for judicial review of this MAC and alleged that the MAP: (1) erred in law in failing to take into account when assessing the deduction for the proportion of impairment due to Ms Wills' pre-existing conditions that at the time of her injury they were being effectively managed and controlled by medication and ongoing professional treatment; and (2) failed to give any adequate reasons for disregarding or discounting the fact that those pre-existing conditions were being so managed and controlled when assessing their contribution to her current degree of permanent impairment.

Meagher J dismissed the Summons and ordered the plaintiff to pay the worker's costs. His reasons are summarised as follows.

His Honour rejected ground (1). The plaintiff asserted that in addressing the issue of causation: (1) the pre-existing condition was "*properly not viewed as being symptomatic [but rather] as being managed by medication*"; (2) it was wrong to evaluate "*the contribution of the pre-existing condition by reference to it being clinically asymptomatic*"; and (3) any absence of symptoms before the injury had to be considered in the context where the pe-existing conditions were in remission or under a substantial course of treatment. It also argued that if that approach was not taken, "*the treatment creates a false baseline for the causal enquiry*".

His Honour held that the MAP did not address the question of the causal significance of the pre-existing conditions solely on the basis that they were asymptomatic at the time of her work injury. It considered the fact that they were asymptomatic at that time, but also considered other indications of the causal significance of those conditions. It declined to apply the methodology described in the Guidelines because it would produce an "*anomalous assessment*" that did not reflect the AMS' finding that the pre-existing conditions contributed to the current impairment. Further, in assessing the "*extent*" of that contribution, the MAP considered the "*severity and chronicity"* the worker's relapsing and remitting psychiatric illness *"which the history shows to have been associated with recurrent periods of psychosocial and vocational impairment*".

His Honour noted that this analysis did not have regard to any differences in the worker's medical or other treatment over the years, or to her adherence to any treatment regimes, which in either case might have explained particular periods or occasions of relapse or recurrence. However it was not argued that the MAP should have undertaken such an analysis and held that the MAP was justified in proceeding on that basis.

His Honour also rejected ground (2). He referred to the MAP's obligation to give reasons, as stated in *Campbelltown City Council v Vegan,* and noted that its function was *"to form and give its own opinion on the medical question referred to it by applying its own medical experience and its own medical expertise": Wingfoot Australia Partners Pty Ltd v Kocak.* However, its function was not to decide a dispute or make up its mind by reference to competing contentions or competing medical opinions or to opine on the correctness of other opinions on the relevant medical question. It was required to explain the actual path of reasoning by which it arrived at the opinion it in fact formed on the medical question referred to it and the statement of reasons must explain that actual path of reasoning in sufficient detail to enable a court to see whether the opinion does or does not involve any error of law.

His Honour held that the MAP was required to assess the extent to which the worker's current WPI was due to the pre-existing psychiatric illness and to express that as a percentage of the impairment. This involved a broad evaluation of the extent to which the work injury and the pre-existing conditions contributed to the overall impairment in circumstances where the happening or existence of each was a *"necessary*" condition for the resulting impairment. This involved the weighing of competing considerations regarding the causal significance of each, requiring the exercise of clinical judgment about matters on which expert medical minds might reasonably differ. He stated:

> 29. The Appeal Panel sufficiently identified those competing considerations at Reasons [64], and as the discussion of the Panel's reasons appearing above shows the Panel did not in its analysis disregard the fact that Ms Wills' pre-existing condition was under medication and asymptomatic at the time of her work injury. Accordingly the reasons were not inadequate in the respect contended.

WCC – Presidential Decisions

Sections 281 & 282 WIMA – requirement for worker to submit to a medical examination at the request of the employer – worker resides overseas and is unable to obtain a visa to enter Australia – No discretion – Wattyl Australia Pty Limited v McArthur [2008] NSWCA 326 discussed and applied

Thadsanamoorthy v Teys Australia Southern Pty Limited [2019] NSWWCCPD 61 – Deputy President Parker SC – 9 December 2019

Stop press: WIRO has been advised that the appellant worker intends to appeal against this decision to the Court of Appeal. WIRO will report on the outcome in due course.

The appellant injured his left knee at work on 11 November 2014. He was an unauthorised refugee and a Protection Visa was declined on 14 August 2013. On 2 August 2016, he was deported to Sri Lanka following an unsuccessful review by the AATA.

On 27 March 2017, Arbitrator Bamber issued a COD, which found for the appellant regarding injury, determined that his incapacity was likely to be of a permanent nature; and subject to the requirements of s 53 *WCA*, he was entitled to continuing weekly payments from 2 August 2016 at the rate of $646 per week under s 37 *WCA.*

On 11 September 2017, the appellant was medically examined in Sri Lanka by Dr T Silva and he assessed 25% WPI as a result of the work injury. On 18 December 2017, the appellant's solicitors claimed compensation under s 66 *WCA* from the respondent.

On 25 January 2018, the respondent's solicitors advised the appellant's solicitors that the insurer required him to undergo a medical examination and that it would consider paying his travel expenses to return to Australia for that purpose if he was able to enter the country. On 5 April 2018, the appellant's solicitor replied that he was unable to obtain a visa to come to Australia. However, on 20 April 2018, the respondent's solicitors re-iterated that he was required to undergo a medical examination in accordance with s 281 *WIMA.*

Arbitrator Batchelor conducted an arbitration hearing and identified the issues as being: (1) whether the appellant provided the respondent with all relevant particulars about the claim in accordance with s 281 (2) (b) *WIMA* by failing to submit himself to a medical examination as requested by the respondent, such that the claim can be properly be determined and a decision made on liability as required by the section? and (2) whether the ARD was properly filed?

On 29 April 2019, the Arbitrator issued a COD and determined that the appellant had not provided the respondent with all relevant particulars of the claim as required by s 281 (2) (c) *WIMA.* He therefore struck out the ARD.

The appellant appealed and asserted that the determination was affected by errors of fact, law and discretion as follows: (1) The Arbitrator failed to apply the correct statutory construction of ss 281 and 282 *WIMA*, particularly the interaction of the procedural requirements of s 282 with the substantive sections of the *WIMA* and the *WCA;* (2) The Arbitrator unduly restricted the ambit of his discretion in his determination that the appellant had failed to '*provide all relevant particulars about the claim*'; (3) The Arbitrator's determination that the exercise of his discretion would only be initiated by unconscionable actions of the Respondent was erroneous; (4) The Arbitrator erred in respect of the discretionary elements of his judgment; and (5) The Arbitrator failed to give adequate reasons for his decision.

Deputy President Parker SC determined the appeal on the papers. He noted that the Arbitrator concluded as a practical matter that the appellant would not be granted a temporary visa to enter Australia for the purpose of attending the respondent's medical examination and this conclusion was not challenged. The Arbitrator commenced his substantive Reasons under an intermediate heading "*Discretion*" and then analysed the decision of the Court of Appeal in *Wattyl Australia Pty Limited v McArthur* and stated:

> 47. Her Honour held at [99] that the plain reading of Sch 6 Pt 18C (8) of *the 1987 Act* specified that the procedural provisions of Ch 7 of *the 1998 Act* had to be complied with. This was in accordance with the judgement of Young CJ in EQ in the case, and of Grove J who agreed with the orders proposed by his Honour on the facts and circumstances of the case as found by him.
>
> 48. Grove J held that s 280A of *the 1998 Act* had to be complied with in order for a claim for work injury damages to be made. This was irrespective of the prospects of success of such a claim …
>
> 49. Neither Young CJ in EQ nor Grove J dealt with the discretion of a court to waive compliance with the procedural requirements of *the 1998 Act* in respect of claims for lump sum compensation or work injury damages as did Beazley JA. They held that the procedural requirements of *the 1998 Act* had to be complied with…
>
> 51. Her Honour went on to find, as noted above at [47], that the worker's claim was governed by the procedural provisions of *the 1998 Act*, and that the claimant's appeal against the dismissal of its motion by Balla DCJ should be upheld.
>
> 52. My view is therefore that the [appellant] does not gain any assistance from the decision in *Wattyl*, which makes it quite clear that the procedural provisions of *the 1998 Act* must be complied with in respect of a claim for, in this case, lump sum compensation. Sections 281 and 282 of the 1998 Act are all contained in Division 4 of Part 3 of Ch 7 of *the 1998 Act* – '*Claims for Lump Sum Compensation and Work Injury Damages'*, which also includes s 280A, the subject of proceedings in *Wattyl*. I find that there is no discretion to waive compliance with the procedural requirements for making a claim for lump sum compensation.
>
> 53. If I am wrong in this finding, for the reasons highlighted by Beazley JA at [88] in *Wattyl* … I cannot see any conduct on the part of the respondent that would be relevant to the exercise of a discretion to waive compliance by the [appellant] with the procedural requirements of *the 1998 Act* in respect of his claim for lump sum compensation.

On the hypothetical basis that there was a discretion to be exercised, the Arbitrator listed a number of matters going to the exercise of that discretion and then held that there was no discretion to waive compliance with the procedural requirements for making a claim for lump sum compensation, but held that if there was such a discretion, he would not have exercised it in favour of the appellant.

Parker ADP summarised the appellant's submissions as follows:

> (a) The decision effectively ousted the jurisdiction of the medical assessors.
>
> (b) There being no issue as to injury or as to the level of impairment as a result of that injury, the jurisdiction of the Commission was exhausted, and the remaining issues were matters which were exclusively within the purview of the medical assessors.
>
> (c) The system is non-adversarial.

(d) The utility of the examination of the appellant by a doctor qualified on behalf of the respondent would be to "*justify acceptance of the appellant's claim if the respondent's doctor agreed with the appellant's doctor*" but as it was unlikely that there was ever going to be agreement as to the level of impairment the matter would have to be referred to an AMS in any event.

(e) Section 282 (2) of *the 1998 Act* is purely procedural in its nature. Further, it is submitted, the section is an inconsequential procedural requirement. In the circumstances, s 282 (2) is, it is submitted, a subordinate provision. The provisions dealing with the appellant's entitlement to weekly compensation, lump sum compensation and entitlement to bring a work injury damages claim are leading provisions and a subordinate provision should never be allowed to override entitlements under the workers compensation legislation, particularly where the inability to comply with the procedural requirements is not the fault of the appellant. The aim of the workers compensation legislation is to provide fair compensation to workers who are injured and a strict interpretation of s 282 (2) by the Commission Arbitrator defeats that overriding purpose (s 3 of *the 1998 Act*, "*System objectives*").

(f) The discretion referred to by Beazley JA in *Wattyl* was limited by the Arbitrator to "*a discretion which can only be exercised following an examination of the behaviour of the parties*." The discretion referred to by Beazley JA, it is submitted, is much wider than that and extends to situations where gross injustice would result from the literal interpretation of a statute or the failure to rank statutes in order of priority depending on their importance. Discretion should be exercised in this instance to remedy the injustice not the behaviour of the party.

(g) The Arbitrator's assertion that he was constrained by the decision in *Wattyl* to dismiss the appellant's claim for lump sum compensation is with respect too narrow an application of this decision. The procedural breaches in *Wattyl* were substantive. There is no evidence that the claimant had an impairment of 15% and the claimant had not engaged in the numerous administrative requirements of work injury damages claims. In this case the only impairment to the appellant's entitlements is an inconsequential medical examination.

(h) If the dispute is defined widely as to whether the appellant is entitled to lump sum compensation then it is submitted that the respondent is in breach of its obligations as referred to in s 285 of *the 1998 Act*.

(i) The decision is determining a medical issue based on adversarial considerations. The intention of the medical assessment system is to remove adversarial assessment of the whole person impairment.

(j) The Arbitrator did not explain why he came to a conclusion that if there had been a discretion he would not have exercised it in favour of the appellant. In particular the Arbitrator failed to exercise a discretion having regard to the severe prejudice that the appellant suffered as a result of his determination.

(k) No reasons were given as to why the Arbitrator would decline to exercise the discretion in the appellant's favour. The Arbitrator did not consider or give reasons in respect of the effect of his decision on the substantive rights that the appellant would lose as a result of the determination

Parker ADP summarised the respondent's submissions as follows:

In relation to ground (1) - the appellant's argument appeared to be that the Arbitrator was required to ignore the clear words of the legislation, as to do otherwise would deprive the appellant of his substantive rights.

The respondent referred to the decisions of *Wilson and Cross v Secretary, Department of Education,* which were directed to the circumstances of a particular provision. In *Cross* the meaning of the provision was uncertain and in *Wilson* there was a conflict in the operation of the provisions, but neither of those circumstances is present in this matter. It argued:

> In this appeal the provisions relied upon by the Respondent and used as the basis of the Arbitrator's determination are clear in their meaning and intent. They do not conflict with the substantive provisions but set a pathway for a claimant to establish an entitlement to a claim under those substantive provisions. The Arbitrator was correct to accept that there was no discretion to ignore those provisions because of a perceived injustice arising from the Appellant's particular circumstances presently being out of the jurisdiction.

The respondent referred to the decisions in *ADCO Constructions Pty Limited v Goudappel* and *Wattyl*, and asserted that the passages quoted from Beazley JA's decision are obiter.

In relation to grounds (2) to (4) - the passage from Beazley JA in *Wattyl* at [88] *"needs to be viewed in the context of her Honour finding the proceedings were maintainable, and that it was incumbent on the defendant to raise the non-compliance in response to the proceedings".* It argued:

> Her Honour's comments make it clear that in the setting of the same legislative scheme, and whilst not limiting the Court's discretion, the focus of the exercise of that discretion should not be on any perceived injustice to the Appellant, but rather the manner and timing in which the non-compliance was raised by the employer.

In relation to ground (5) – the Arbitrator's reasons are far from meeting the test of being so inadequate as to amount to a miscarriage of justice. He outlined the various balancing issues he considered on the discretionary issue and was clearly alert to the appellant's position regarding the practical consequences of striking out the application.

The respondent also replied to a further ground raised by the appellant regarding the jurisdiction of the Arbitrator and stated that: (a) the point was not taken at the hearing; (b) Section 289 (3) makes it clear a dispute in relation to lump sum compensation cannot be referred to the commission for determination unless the respondent has either disputed liability, made a settlement offer or failed to determine the claim as required. None of those grounds were met; (c) Under s 288 (2) *WIMA*, the Registrar has limited powers; and (d) The Arbitrator was not determining a medical dispute.

On 12 November 2019, the Commission issued a Direction to the parties asking, inter alia:

> *(1) Whether (in relation to s 282 (2)) the medical practitioner had to be qualified to practice in NSW?*

The appellant argued that the medical practitioner did not need to be qualified to practice in NSW and that they could be qualified in a foreign jurisdiction. However, the respondent argued that the medical practitioner had to be registered under the Health Practitioners Regulation National Law and this required a practitioner to be qualified under the law in a medical profession and they had to be qualified under the Workers Compensation Guidelines.

> *(2) Whether the appellant must be present in NSW in order to submit himself for examination, or he could do so in Sir Lanka?*

The appellant argued that if the employer were to provide and pay for an examination in Sri Lanka, and the appellant presented himself for that examination, he would have complied with s 282 (2) *WIMA.* However, the respondent argued to the contrary having regard to s 12 of the *Interpretation Act 1987* and the decision in *Wesfarmers General Insurance Limited v Nestel.*

> *(3) Whether the obligation on the employer to provide and pay for the medical practitioner who examines the appellant extends to a requirement that it provide for a medical practitioner to examine the appellant in Sri Lanka or some other venue convenient to the parties?*

The appellant argued, "*If an employer arranges an examination which it is possible for the worker to attend, then clearly there is an obligation on the worker to attend that examination if he/she seeks to proceed with a claim. Conversely, an employer may choose to decline the opportunity of having a worker examined*." Further, enquiries by his its solicitors indicated that a medical practitioner practising in Colombo has been qualified pursuant to iCare Guidelines to assess whole person impairment. However, the respondent argued that the medical examination is required to take place in NSW and the employer does not have an obligation to provide for a medical practitioner to examine the appellant in Sri Lanka or some other venue to which he may be able to travel.

Parker ADP dismissed the appeal for reasons that are summarised below.

Ground (1) – Statutory construction of ss 281 and 282 WIMA

Parker ADP held that s 281 is intended to promote the early determination of liability and assessment of claims for lump sum compensation and to facilitate that objective, s 282 requires the claimant to provide "*relevant particulars about the claim … sufficient to enable the insurer, as far as practicable, to make a proper assessment of the claimant's full entitlement on the claim*".

The emphasis is on providing information to the insurer to enable it to make an expeditious and early determination of liability and, if liability is accepted, to make an early and reasonable offer of settlement. Sub-section 282 (2) facilitates that purpose by directing that the employer can have the claimant examined and its intent is to avoid referral to an AMS and to enable the parties to resolve medical disputes. Until such time as the claimant submits for examination "*the claimant is not considered to have provided all relevant particulars about the claim*". The failure to supply the particulars, including attendance at a medical examination, engages s 281 (2) (b).

Parker ADP held that the text of ss 281 and 282 does not permit of a discretion. The language reposes such discretion as may exist in the insurer in the sense that the option provided is for the insurer to have the claimant examined or not examined. There is no option provided for a claimant for lump sum compensation not to be examined if the employer requires the claimant to submit for examination. He stated:

> 72. In *Gordon*, Gleeson CJ, Gummow, Hayne, Heydon and Crennan JJ said:
>
> > 15. In the adversarial system of justice, choice rests primarily with the parties and it is generally the case that the court's power of decision or order is exercised upon the application of a party. Generally, there is in law no restriction upon a person's right to start an action and to carry it to the point at which a choice is cast upon the defendant to make some response in order to avoid judgment in default. Once the procedural law has been engaged, all parties to the litigation are subject to it.
> >
> > 16. None of the above denies the possibility of a defendant denying the plaintiff's right to invoke the jurisdiction of the court, for example where the plaintiff's right is conditional upon there being an action cognisable within that jurisdiction. However, the material point is that that denial must be made within the structure of the relevantly engaged procedural law, and not outside it ….

73. When the procedural law is engaged a party is put to a choice. Under the provisions of the 1998 Act, when the appellant made a claim for lump sum compensation the insurer was put to a choice as to whether it wished to have the appellant medically examined. It chose to do so and by virtue of s 282 (2), until such time as the appellant was medically examined, he was "*not considered to have provided all relevant particulars about the claim*" thus postponing the period of time during which the insurer was required to determine the claim in accordance with s 281 (1).

74. Because the claimant could not attend in Australia for the proposed medical examination, the "*relevant particulars*" were not furnished. Therefore the time within which the insurer was required to determine the claim as specified in s 281 (2) (b) did not commence to run.

75. Compliance with s 281 (2) (b) is mandatory on the insurer only in so far as it is provided with "*all relevant particulars about the claim*". It is up to the insurer to determine whether it wishes to have the claimant medically examined. If it does so, there is no discretion in the Commission to override the insurer's requirement in this regard.

76. In *Wattyl* the Court held that the worker was required to comply with the pre-trial procedures. The appellant's position in this matter is similar. The Court will enforce procedural compliance if the insurer insists as the reasons for judgement of Beazley JA in *Wattyl* make plain:

> 89. The claimant also made it apparent, at least in its argument on the appeal, that it seeks compliance with all of the pre-trial procedures prescribed by the [*1998 Act*]. In those circumstances, subject to the consideration of the opponent's argument that his claim was not governed by the legislation at all, I am of the opinion that the trial judge wrongly exercised her discretion in dismissing the opponent's motion.

77. In the same case Young CJ in Eq said:

> 158. I consider that it is impossible to construe the [1998 Act] in the way the opponent suggests. The provision which have [sic] been set out seem to me to indicate that there are a closed number of categories of claims that can be considered and that these must be considered under the procedural provisions of the legislation whether or not they occurred after the passing of the 2001 amendments.

78. Likewise, Grove J said:

> 191. The inhibitory words of s 280A do not operate only if the injured worker can be perceived to have a claim for lump sum compensation which will succeed. The provision requires the making of a claim not the demonstration of an entitlement. If a claim for work injury damages is desired to be pursued in respect of *an injury then it cannot be made* unless a claim for lump sum compensation is made in respect of *the injury* before or at the same time. It is conceivable that a claim for lump sum compensation may ultimately fail, for example, by reason of a subsequent finding that the resulting impairment was not permanent, but the unambiguous words of the provision require the claim to be made. Its operation is not dependent upon the determination of the claim. (emphasis in original)

79. In *Wattyl* the Court of Appeal granted leave to appeal and allowed the appeal. It thereby reversed the finding of the primary judge that non-compliance with s 280A could be excused. The only member of the Court to discuss whether there was a discretion to excuse non-compliance was Justice Beazley. Her Honour's conclusions

> were based on her analysis of the binding ratio in *Gordon*. The point is that when a party invokes by way of defence non-compliance with the procedures and processes specified in the legislation the court deals with such an application "*in accordance with ordinary discretionary principles that may depend on many different factors*".
>
> 80. In my view, there is no alternative in terms of the construction of s 282 (2). If the insurer insists on an examination, the worker is required to submit. Until such time as he does, the relevant particulars have not been furnished.

Significantly, with respect to the operation of the Scheme, Parker ADP stated:

> 81. In my view, there is nothing that would prevent the insurer from having the examination conducted by an appropriately qualified medical practitioner in Sri Lanka or some other venue to which the appellant could conveniently travel. Furthermore, I see no reason why the insurer could not, as the worker did, have a New South Wales practitioner travel to Sri Lanka for the purpose of the examination. However, I can see no basis in the legislation to require an insurer to take these steps to facilitate its examination.
>
> 82. A reasonable construction of s 282 (2) requires the medical practitioner to be a suitability qualified health practitioner practising in New South Wales or at least Australia and trained in the Workers Compensation Guidelines. This in my view follows from the guidelines themselves.

Grounds (2) to (4) – Discretion

Parker ADP held that if there is a discretion to, in effect, excuse the claimant from attending for medical examination when required to do so by the insurer, then any such discretion is a judicial discretion. A judicial discretion must be exercised for the purpose for which it is provided under the empowering statute and for reasons clearly expressed and in accordance with the statutory purpose.

The Arbitrator addressed that issue concluding that there was nothing in the conduct of the respondent that would be relevant to the exercise of a discretion to waive compliance by the appellant with the procedural requirements, but that was not the only consideration he embraced. He made clear that in his opinion the insurer had stated its requirement that the appellant should undergo a medical examination and agreed to cover the travel expenses for a return to Australia for that purpose. He accepted that an examination was relevant having regard to the matters raised by Dr Pillemer in his report and the differences in movement recorded by the doctors who examined the appellant in January 2016. Dr Pillemer recorder that the report from Dr Silva contained what Dr Pillemer perceived to be numerous mistakes. Finally, there was the issue of the appellant's failure to inform the insurer of the proposed claim for lump sum compensation, presumably before he was deported from Australia on 2 August 2016, in circumstances where he was examined by doctors before he was deported.

Ground (5) – Discretion

Parker ADP held that the Arbitrator's reasons satisfy the three fundamental requirements for a statement of reasons as set out in *Beale v GIO of New South Wales*, in which Meagher JA said:

> No mechanical formula can be given in determining what reasons are required. However, there are three fundamental elements of a statement of reasons which it is useful to consider. First a judge should refer to relevant evidence. There is no need to refer to the relevant evidence in detail, especially in circumstances where it is clear that the evidence has been considered … Secondly a judge should set out any material findings of fact and any conclusions or ultimate findings of fact reached. …

> Thirdly a judge should provide reasons for making relevant findings of fact (and conclusions) and reasons in applying the law to the facts found.

Parker ADP noted that there was no complaint that the Arbitrator failed to consider the relevant evidence or that he did not set out the material findings or ultimate findings of fact he relied on for his decision. Further, the grammatical meaning of ss 281 and 282 is straight forward and without ambiguity. The Arbitrator gave clear expression to his reasons for finding that he did not have a discretion to excuse the appellant from attending for medical examination and he gave cogent reasons why, if contrary to his view he had such a discretion as contended for, he would not have exercised it in the appellant's favour. He stated:

> 99. I do not see that proper and adequate reasons required the Arbitrator to make express reference to the present consequence for the appellant's substantive claim. This would not add to the appellant's understanding of the reasons for his lack of success or to an understanding of the reasoning for the purpose of appellate review.

In relation to jurisdiction, Parker ADP held that this point was not argued before the Arbitrator, it was not raised in the grounds of appeal and it should be rejected. He held:

> 104. Section 105 of *the 1998 Act* confers, subject to the Act, exclusive jurisdiction on the Commission "to examine, hear and determine all matters arising under this Act and the 1987 Act." In my view, the Arbitrator exercised the jurisdiction conferred by s 105.
>
> 105. I reject the appellant's submission that the Arbitrator "*effectively*" or otherwise ousted the jurisdiction of the medical assessors. Further, I reject the submission that the issue was "*exclusively within the purview of the medical assessors.*"

Accordingly, Parker ADP confirmed the COD.

Approach to expert evidence considered

Westpac Banking Corporation v Chauhan [2019] NSWWCCPD 63 – President Judge Phillips – 10 December 2019

The worker has been employed by the appellant as a bank officer in an in-bound call centre since early 2008. She alleged injuries to her neck, both elbows and wrists as a result of excessive typing and using the mouse at work. On 1 September 2017, she reduced her working hours to 22 hours per week and claimed continuing weekly compensation from 1 September 2017 and s 60 expenses. However, the appellant disputed the claim.

On 11 June 2019, ***Arbitrator Read*** issued a COD, which determined that the worker's employment aggravated her bilateral cubital tunnel condition under s 4 (b) (ii) *WCA.* After analysing the expert medical evidence, he held that the opinions of Associate Professor Wong was to an extent consistent with that of Dr Paul, that the worker's condition was exacerbated by both work and non-work factors, and with the opinion of Dr Gupta who opined that there was a connection to the work duties. He did not accept that the worker's symptoms were the ordinary consequences of her underlying condition.

The Arbitrator accepted that as a matter of common sense it was reasonable to infer that the worker's work activities were longer in duration and intensity and involved much more extensive use of the wrists and hands than domestic tasks, and he found that there was adequate evidence of a temporal connection between the work and the worsening condition.

The Arbitrator held that the worker was incapacitated as a result of this condition and he awarded continuing weekly payments from 1 September 2017, pursuant to ss 36 and 37 *WCA,* and s 60 expenses (with respect to the cubital tunnel syndrome only). He found that the worker did not injure her neck and he entered awards for the respondent.

On appeal, the appellant alleged that: (1) The decision is affected by an error of fact, law or discretion in so far as it failed to identify an injury for which there was expert medical support, notwithstanding it was noted such expert guidance was required by the Commission; and (2) The decision is affected by an error of law due to the failure to consider whether the relevant incapacity was as a result of the injury; this error stands alone but also proceeds from the initial error of an imprecise identification of the injury.

President Judge Phillips determined the appeal on the papers and dismissed it. His reasons are summarised below.

Ground (1)

The appellant argued that the Arbitrator's finding of injury was based upon the opinion of Dr Gupta, which is based on unproven assumptions of the facts. There is no evidence from the worker to suggest that she leant on her elbows and there is no explanation from Dr Gupta as to how or why the use of a telephone or computer might cause or aggravate the cubital tunnel condition. His does not set out the relevant mechanism for causation and does not express a view on the relevant causal test (main contributing factor) and does not satisfy the requirements for expert evidence set out in cases such as *Makita (Australia) Pty Ltd v Sprowles.* It also argued that the Arbitrator erred by relying upon the opinions of Associate Professor Wong and Dr Paul, as neither diagnosed cubital tunnel syndrome, and his finding was made by conflating their opinions.

The worker argued that the appellant failed to identify specific errors. She relied upon the decision in *Paric v John Holland (Constructions) Pty Ltd* and argued that the history or facts assumed by an expert do not have to precisely correlate with the evidence, provided that such history constitutes "*a fair climate for the opinions they express*". Therefore, the Arbitrator was entitled to give weight to Dr Gupta's opinion and he was entitled to rely on aspects of Dr Paul's reports, including that the symptoms were exacerbated by work.

His Honour stated:

74. In *Makita*, Heydon JA found as follows:

> The basal principle is that what an expert gives is an opinion based on facts. Because of that, the expert must either prove by admissible means the facts on which the opinion is based, or state explicitly the assumptions as to fact on which the opinion is based. If other admissible evidence establishes that the matters assumed are 'sufficiently like' the matters established 'to render the opinion of the expert of any value', even though they may not correspond 'with complete precision', the opinion will be admissible and material: see generally Paric v John Holland Constructions Pty Ltd [1984] 2 NSWLR 505 at 509-510; Paric v John Holland Constructions Pty Ltd [1985] HCA 58; (1985) 59 ALJR 844 at 846. One of the reasons why the facts proved must correlate to some degree with those assumed is that the expert's conclusion must have some rational relationship with the facts proved. (emphasis added)

75. And further:

> In short, if evidence tendered as expert opinion evidence is to be admissible, it must be agreed or demonstrated that there is a field of 'specialised knowledge'; there must be an identified aspect of that field in which the witness demonstrates that by reason of specified training, study or experience, the witness has become an expert; the opinion proffered must be 'wholly or substantially based on the witness's expert knowledge'; so far as the opinion is based on facts 'observed' by the expert, they must be identified and admissibly proved by the expert, and so far as the opinion is based on 'assumed' or 'accepted' facts, they must be identified and proved in some other way; it must be established that the facts on which the opinion is based form a

proper foundation for it; and the opinion of an expert requires demonstration or examination of the scientific or other intellectual basis of the conclusions reached: that is, the expert's evidence must explain how the field of 'specialised knowledge' in which the witness is expert by reason of 'training, study or experience', and on which the opinion is 'wholly or substantially based', applies to the facts assumed or observed so as to produce the opinion propounded. If all these matters are not made explicit, it is not possible to be sure whether the opinion is based wholly or substantially on the expert's specialised knowledge. If the court cannot be sure of that, the evidence is strictly speaking not admissible, and, so far as it is admissible, of diminished weight. And an attempt to make the basis of the opinion explicit may reveal that it is not based on specialised expert knowledge, but, to use Gleeson CJ's characterisation of the evidence in HG v R [1999] HCA 2; (1999) 197 CLR 414, on 'a combination of speculation, inference, personal and second-hand views as to the credibility of the complainant, and a process of reasoning which went well beyond the field of expertise' (at [41]). (emphasis added)

His Honour stated that in *Hancock,* Beazley JA considered the application of *Makita* to Commission proceedings and held:

> 82. Although not bound by the rules of evidence, there can be no doubt that the Commission is required to be satisfied that expert evidence provides a satisfactory basis upon which the Commission can make its findings. For that reason, an expert's report will need to conform, in a sufficiently satisfactory way, with the usual requirements for expert evidence. As the authorities make plain, even in evidence-based jurisdictions, that does not require strict compliance with each and every feature referred to by Heydon JA in *Makita* to be set out in each and every report. In many cases, certain aspects to which his Honour referred will not be in dispute. A report ought not be rejected for that reason alone.
>
> 83. In the case of a non-evidence-based jurisdiction such as here, the question of the acceptability of expert evidence will not be one of admissibility but of weight. This was made apparent in *Brambles Industries Limited v Bell* [2010] NSWCA 162 at [19] per Hodgson JA. That is the way that Keating DCJ dealt with Dr Summersell's evidence in this case, so that is not the relevant error. (emphasis added)

His Honour rejected the appellant's argument that strict non-compliance with *Makita* is fatal to the Arbitrator placing any reliance upon Dr Gupta's report. He did not read the authorities of *Makita, Paric* and *Hancock* as necessarily presenting an either/or choice for a decision maker. He stated that *Makita* sets out in comprehensive terms the proper approach for the tribunal of fact when considering expert evidence. In *Makita*, Heydon JA himself refers to *Paric* and acknowledges that an opinion will be admissible and material even though the facts established may not correspond with complete precision.

His Honour therefore held that *Makita* does not stand for "*the rather stark proposition asserted by the appellant in this matter, that namely if the facts are not proven to substantiate the opinion, the opinion is inadmissible or ought be accorded little or no weight.*" At [64] of *Makita*, Heydon JA acknowledges that "*other admissible evidence may be available to substantiate the opinion*". In any event, *Makita* was decided before *Hancock*, which specifically dealt with how *Makita* is to be applied in the context of a tribunal not bound by the rules of evidence. Beazley JA held that strict compliance with each and every feature referred to by Heydon JA in *Makita* is not required. What is required is for the Commission to be satisfied that the expert evidence provides a satisfactory basis upon which the Commission can make its findings.

His Honour held that the Arbitrator closely examined the medical evidence and that he was correct to accord little weight to the opinion of Associate Professor Wong, as there was no sufficient factual basis contained within that report, consistent with *Paric* and *Hancock.* That essentially reduced the contest in the medical evidence to the issue of resolving the differences between the diagnoses reached by Dr Gupta and Dr Paul. In approaching this task, it was entirely appropriate for the Arbitrator to glean from the various reports the fact that the worker gave a history that her work duties caused an increase in her symptoms and that fact was not seriously challenged. Ultimately, he accepted Dr Gupta's diagnosis of cubital tunnel syndrome, which is available on the evidence, and no error is established.

Ground (2)

The appellant argued that the Arbitrator failed to consider whether or not the alleged incapacity was a result of any injury. He erred in his reasoning by accepting the allegation of exacerbation of an underlying condition and not addressing whether or not there had in fact been an injury. However, the worker argued that his ground is misconceived as the Arbitrator's reasons expressly considered whether her incapacity resulted from injury.

His Honour held that this ground has no merit, but he felt it necessary to consider how "*injury*" has been dealt with by the Commission and the Compensation Court, as follows:

> 102. In *Lyons v Master Builders Association of NSW Pty Ltd* Neilson CCJ observed as follows:
>
> > Indeed, if I might respectfully say so, the majority decision in *Colliar v Bulley* really fails to distinguish between the receipt of the injury or the injurious event and the pathology arising from the event. Unfortunately, the word 'injury' refers to both the event and the pathology arising from it. It is often necessary to draw the distinction. The Act makes the receipt of injury compensable, not the injury itself.
>
> 103. This approach has been followed by this Commission, for example in cases such as *Department of Juvenile Justice v Edmed*. In this case the learned Arbitrator has found, based upon not speculation but Dr Gupta's findings upon operative intervention, that Ms Chauhan suffered from cubital tunnel syndrome. The learned Arbitrator has accepted that this disease or condition has on the medical evidence, when taken with Ms Chauhan's complaints, been relevantly aggravated by her employment with the appellant which is precisely the type of circumstance that s 4 (b) (ii) of *the 1987 Act* covers and which his Honour Neilson CCJ (as he then was) avers to in *Lyons*. Ground Two is not made out and is thus dismissed.

His Honour corrected an error in the COD, such that it correctly found that injury occurred on 1 September 2017.

Whether proposed treatment is reasonably necessary – Rose v Health Commission (NSW) & Diab v NRMA Ltd discussed – Requirement to establish an error of fact, law or discretion under s 352 (5) WIMA

Toll Holdings Limited v Doodson [2019] NSWWCCPD 62 – Deputy President Wood – 10 December 2019

The worker injured his left knee at work in 2009 and 2010. Following the second injury the worker underwent 2 arthroscopies and a cartilage harvest and reimplantation in 2010. On 12 December 2011, Dr Manohar implanted a permanent spinal stimulator, but on 14 July 2012, the worker was involved in a MVA and the stimulator was dislodged. It was removed on 3 October 2014. On 20 July 2018, he had a total left knee replacement and on 22 October 2018, he had a left knee manipulation. He developed a chronic regional pain syndrome in the left lower extremity and complained of pain in his right knee, back and shoulder.

On 15 November 2018, the worker sought approval for a trial DRG stimulator, which was said to be more-advanced than the previous implant, but the appellant disputed that claim on the grounds that: the previous stimulator was a failure; the worker had not exhausted all conservative treatment and had not been compliant with such treatment; and it did not consider that the proposed treatment would alleviate the symptoms or result in an improvement of the worker's condition.

On 30 May 2019, ***Arbitrator Burge*** conducted an arbitration . On 7 June 2019, he issued a COD and determined that the trial of the DRG stimulator was reasonably necessary. However, the appellant appealed and argued that: (1) the Arbitrator erred in fact and law in applying the relevant authorities to the facts; (2) there was insufficient evidence to determine the matter; (3) the Arbitrator ought to have considered alternative treatment modalities and rejected the proposed treatment, and (4) the Arbitrator failed to take into account the respondent's psychological condition, which was referred to in the notes and referred to by A/Prof Shatwell.

Deputy President Wood noted that the arbitrator referred to and quoted the relevant parts of the decisions in *Rose* and *Diab* and discussed the matters referred to in those decisions, which were required to be considered in determining whether treatment was reasonably necessary. In particular, he recorded the summary of considerations provided by DP Roche in *Diab,* as follows:

> In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* …, namely:
>
> (a) the appropriateness of the particular treatment;
>
> (b) the availability of alternative treatment, and its potential effectiveness;
>
> (c) the cost of the treatment;
>
> d) the actual or potential effectiveness of the treatment, and
>
> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.

Applying those considerations, the Arbitrator:

> (a) preferred the opinion of Dr Ho (which was supported by Dr Assem and Dr Morsinghe) that the proposed treatment was appropriate. He accepted that the previous stimulator provided the worker with some benefit before the MVA occurred and that the proposed stimulator was more advanced.;
>
> (b) noted that the worker had undergone a range of surgical and conservative treatments, which provided limited or no benefit. Applying *Diab*, it was not necessary to show that the proposed treatment was reasonably necessary to the exclusion of all other treatment;
>
> (c) noted that the appellant had not submitted that the costs were prohibitive. Although the costs were in the vicinity of $10,000, in the context of the nature and extent of the injury, the costs associated with the treatment could not be said to be unreasonable or prohibitive;
>
> (d) accepted the prognosis of Dr Ho, and in doing so noted that A/Prof Shatwell acknowledged that Dr Ho had greater experience with using stimulators. It was also apparent that A/Prof Shatwell had misread Dr Ho's prognosis as to the likely outcome and inadvertently downplayed the benefits. For those reasons, he did not accept A/Prof Shatwell's views, and

> (e) noted that the appellant did not challenge the experts' acceptance as to the viability of the treatment and there seemed little doubt that the worker did receive some benefit from the earlier stimulator, although not complete relief. The preponderance of the evidence disclosed that the treatment was accepted by experts and was appropriate and effective.

Wood DP rejected ground (1). She held that the Arbitrator thoroughly reviewed the authorities of *Rose* and *Diab* and correctly identified the principles and considerations to be applied in determining whether the proposed treatment was reasonably necessary. He proceeded considered the evidence before him, which included the extensive treatment provided by Dr Manohar before the worker was referred to Dr Ho. He reviewed Dr Ho's evidence, which reported the treatment that the worker had already received, gave a diagnosis, made a recommendation that he should undergo the proposed trial DRG stimulator, and identified the long term benefits of the procedure. The Arbitrator accepted that his evidence satisfied the considerations he was required take into account and there is no identifiable error in that approach. She stated, relevantly:

> 109. The Arbitrator rejected, on a proper basis, A/Prof Shatwell's opinion as to why the DRG stimulator was not reasonably necessary. Having done so, the accepted evidence was sufficient to find the proposed procedure reasonably necessary. The Arbitrator was not required to consider whether the alternate treatment put forward by A/Prof Shatwell was reasonably necessary in the terms identified by Burke CCJ in *Rose* and Roche DP in *Diab*. As the Arbitrator observed, it is not necessary to establish that the treatment was reasonably necessary to the exclusion of all other treatment.

Wood DP held that grounds (2), (3) and (4) are "*simply re-statements of ground one.*" However, the appellant's submissions regarding ground (2) were not put to the Arbitrator and it cannot be an error to fail to refer to a submission that is not made.

As to ground (3), the appellant asserts that the Arbitrator should have considered the treatment proposed by A/Prof Shatwell and found that the DRG stimulator was not reasonably necessary. However, it is not sufficient to simply assert that the Arbitrator should have found in its favour. In *Norbis v Norbis* the High Court observed:

> In conformity with the dictates of principled decision-making, it would be wrong to determine the parties' rights by reference to a mere preference for a different result over that favoured by the judge at first instance, in the absence of error on his part. According to our conception of the appellate process, the existence of an error, whether of law or fact, on the part of the court at first instance is an indispensable condition of a successful appeal.

Wood DP held that in the absence of an identifiable error, a Presidential member has no power to intervene even if he or she preferred a different result, and she did not. In relation to ground (4), she held that the relevant findings were "factual" and that findings of fact will not normally be disturbed if they have rational support in the evidence. There was no indication of error by the Arbitrator and his approach was rational, logical and consistent with *Diab* and *Rose.*

Accordingly, Wood DP dismissed the appeal.

Whether the Arbitrator, having found injury, was correct to find that the appellant had not made out a case of resultant incapacity for 2 closed periods

Heyworth v VMWare Australia Pty Limited [2019] NSWWCCPD 64 – Acting Deputy President King SC – 11 December 2019

The appellant was employed by the respondent from December 2012 to July/August 2013. He suffered a major depressive disorder and associated symptoms arising from stress at work and ceased work in July 2013, but in March 2014, he commenced contract work in a lesser role with Transport for NSW and did this work until about July 2015. He alleged that because of his injury he was unable to do his job properly and his employment was terminated in July 2015. He remained off work until 18 April 2016, but suffered continuing symptoms. However,

The appellant appealed from a decision made by ***Arbitrator Read***, who determined that he had not discharged his onus of proving that he had no current work capacity for the purposes of s 32A *WCA* during 2 closed periods (from 1 December 2013 to 2 March 2014 and from 1 October 2015 to 18 April 2016, respectively) and that he was unable to work in either his pre-injury role or in suitable employment. However, the Arbitrator made an award under s 60 *WCA.*

Acting Deputy President King SC identified the issue for determination on appeal as whether the Arbitrator's factual decision, expressed in paras [121]–[145] (where there is a review of the evidence and comment upon it) displays any error. He noted the following grounds of appeal:

> (1) the Arbitrator erred in fact and/or law or in the exercise of his discretion in finding that the appellant had failed to establish any entitlement to weekly compensation in the period 1 December 2013 to 2 March 2014, and
>
> (2) the Arbitrator erred in fact and/or law or in the exercise of his discretion in finding that the appellant had failed to establish any entitlement to weekly compensation in the period 1 October 2015 to 17 April 2016.

King ADP rejected the grounds of appeal. His reasons are summarised below.

King ADP noted that apart from the appellant's evidence, which was to the effect that he could not work during the periods claimed, there was a considerable body of medical evidence before the Arbitrator that went beyond the issue of injury. The bulk of that evidence did not focus directly on the periods of alleged incapacity and the most direct evidence came from Dr Morse, who did not have detailed knowledge of the appellant's period of employment with Transport for NSW. He stated, relevantly:

> 27. At [121] and [122] of his reasons, the Arbitrator focused on the appellant's resumption of work on 3 March 2014 with TFNSW. He said that it was a common sense proposition that if the appellant could work full time from 3 March 2014, he must have had some capacity for work for some period beforehand. He said: "*Capacity to undertake work does not go from 'no work capacity' to 'current work capacity' on a full-time basis over night.*"
>
> 28. Then as to the appellant's own evidence, the following appears at [123] of the Reasons:
>
> > … There are several features of the [appellant's] evidence that cause me to doubt his assertion that he was totally incapacitated for work in the periods claimed. Whilst the evidence was not the subject of cross-examination, there is no requirement for it to be accepted … (citations omitted).

29. Those features were that the appellant appeared to the Arbitrator to have continued his involvement in recreational and family life "… *unabated, contrary to his claims of deterioratio*n" (emphasis added). This was a reference to the girls' football coaching and prize in the gardening competition. It was possibly also a reference to the family holiday.

30. The next was what the Arbitrator plainly saw as the paucity of evidence about the appellant's commencement of work, through the agency of Ampersand, with TFNSW and the lack of any documentary support in the records for the appellant's evidence as to his difficulties whilst with TFNSW.

31. The Arbitrator dealt separately with the appellant's assertion that he had been terminated by TFNSW because of the continuing effects of his employment injury. Whereas he had, I think it is fair to say, taken the first two matters as casting doubt upon the appellant's evidence rather than completely undermining it, he regarded the documents from TFNSW and, probably, Ampersand, as making this evidence of the appellant "*implausible*". The Arbitrator took the view that something like a termination of employment because of difficulty in performing satisfactorily would be documented, and the documents contain no such indication. This was emphasised at Reasons [127].

32. The Arbitrator then dealt with the second period of the claim, beginning by noting that the reason the period began on 1 October 2016 was obscure. Consistently with what he had said specifically in relation to the first period of claim at Reasons [122], in respect of the second period he said, at Reasons [128] and [132], that in light of his full-time work up to what the Arbitrator took on the strength of the documents to be September 2016, it was implausible that the appellant had no capacity for work starting effectively a month later and that in the absence of evidence explaining why that should be so he, the Arbitrator, doubted *"… the [appellant's] evidence about his work capacity as a whole.*"

33. The Arbitrator returned to this, apparently by way of emphasis, at para [133]. He noted that the medical evidence supported ongoing symptoms, but upon the basis that he had "*… significant concerns about the veracity and reliability of the [appellant's] evidence*". He said, perhaps by way of repetition, that there was no "*cogent or compelling evidence that those symptoms impacted on the [appellant's] capacity to work in any tangible way.*" (emphasis added).

34. Thereafter the Arbitrator at paras [134]–[138] returned to the medical evidence, I think specifically for the purpose of pointing out what he saw as flaws or inadequacies in the evidence of Drs Martin and Cosgrove. This part of the Arbitrator's reasons is consistent with and indeed depends upon his views as to the import of the documentary evidence including the newspaper articles.

King ADP stated that because the decision is a factual one, he should not interfere with it if the decision was fairly open on the evidence. It does not matter whether he might have reached a different view - error must be shown.

King ADP accepted the respondent's submissions to the effect that the appellant was not denied procedural fairness. The relevant evidence was disclosed by the appellant before the hearing. He was represented by able and experienced legal practitioners who must have understood the way that the material would be deployed against him, just as they must have seen the significance of Dr Morse's report when it was embraced by the respondent. He stated, relevantly (citations excluded):

> 51. Ultimately, in my opinion, the Arbitrator's decision can only be seen as one involving the evaluation of the weight of the evidence that was there according to its own terms and in light of absence of evidence which could reasonably be expected to be advanced in support of the appellant's case but which was not before him. After lengthy consideration I have come to the view, which involved overcoming reservations, that it cannot be said that his view was not fairly open. I shall endeavour to explain my analysis of this case which brought me to that view as briefly as possible.
>
> 52. In my consideration of this appeal the part of the Arbitrator's reasons which has given me most pause is to be found in para [133]. I will set out the passage which caused me concern and prolonged consideration. It is as follows:
>
>> I have significant concerns about the veracity and reliability of the [appellant's] evidence. Although the medical evidence supports ongoing symptoms, there is no <u>cogent or compelling</u> evidence that those symptoms impacted on the applicant's capacity to work in any tangible way. The fact of receipt of a compensable injury and treatment for same does not prove incapacity for work. Whilst there is no dispute the [appellant] has suffered a workplace injury which has resulted in a need for investigation and management, in my view the evidence does not support total incapacity during the periods claimed … (emphasis added)
>
> 53. Although some reliance was placed on the fact that the Arbitrator accepted both injury and continuation of some symptoms in the appellant's submissions, something which emerges clearly from the above passage, I am untroubled by that. It is commonplace for people who have suffered injury to be able to work while suffering symptoms of some kind. Rather, of concern to me, is the reference in the above passage to "*cogent or compelling evidence*". There is of course no need for evidence to rise that high to support a finding in any civil litigation in favour of any party to it. That is so even if the *Briginshaw* test is applicable. Satisfaction on the balance of probabilities is all that is called for, and even if a serious matter is in contention, so that to be satisfied on the probabilities a fact-finder should look for a sound evidentiary basis, it is not necessary that the evidence come to more than that.

King ADP was not satisfied that the Arbitrator directed himself to apply a higher standard of proof. He also stated, relevantly:

> 56. But whilst I think the Arbitrator went too far in relation to this part of the evidence, it was only one part of the evidence and it cannot be said to have been of absolutely no weight. Much more importantly to my mind, the Arbitrator thought that the TFNSW/Ampersand records cast doubt on the totality of the appellant's evidence, and as to the cessation of his employment with TFNSW, rendered that evidence implausible. This I think is the real driver of his decision, and in the end, I am unpersuaded that his conclusion was wrong.

Accordingly, King ADP confirmed the COD.

WCC - Medical Appeal Panel Decisions

Anxiety is a symptom and not impairment – Parker v Select Civil Pty Ltd applied

Hand v State of New South Wales [2019] NSWWCCMA 157 – Arbitrator McDonald, Prof. N Glozier & Dr M Hong – 5 December 2019

The appellant was employed by the Ambulance Service of NSW as a trainee paramedic. In October 2012, she was involved in a MVA while she was driving an ambulance under lights and sirens. She suffered physical injuries and began to suffer psychological symptoms after the accident, but returned to work in early 2014 after the physical injuries resolved. She suffered severe anxiety and was placed on selected duties until her resignation in 2017. She was prescribed opioid medication for her physical injuries and developed an opioid use disorder, for which she took medication for the last year.

Thereafter, the appellant worked as a customs officer for about 6 months, but ceased this work because she could not cope with the work and study required. Apart from a short period of casual factory work in December 2018, she has not returned to work.

On 21 August 2019, Dr Morris issued a MAC. He diagnosed PTSD and opioid use disorder, the latter being in remission. He assessed 13% WPI.

However, the appellant appealed against the MAC under ss 327 (3) (c) and (d) *WIMA* and complained about the assessment for "travel" under PIRS. The appellant argued that *the Guidelines* "*stipulate*" that class 1 applies if there is "*no deficit, or minor deficit attributable to the normal variable in the general population: Can travel to new environments without supervision*". The AMS did not comment on whether she had a minor deficit or not and merely recorded that she was able to drive herself to the appointment. He did not take a history of whether or not she travelled without supervision and that she travelled with her mother because of difficulties travelling without supervision or assistance. Therefore, the AMS should have assessed class 2 and not class 1 and he provided insufficient reasons for the assessment of class 1.

However, the respondent argued that the AMS assessed travel and found that class 1 was the "*best fit*" and noted that the appellant's qualified doctor, Associate-Professor Robertson, assessed class 2 because the appellant complained of "travel anxiety in circumstances that are relevant (sic] of the accident". It argued that those circumstances were irrelevant when the appellant ceased work in 2017.

The MAP held (citations excluded):

> 23. Contrary to Ms Hand's submissions, the AMS has given reasons for his assessment, clearly setting out the factors he has taken into account in forming his opinion.
>
> 24. Paragraph 1.6 of *the Guidelines* required the AMS to make an assessment of Ms Hand as she presented on the day of the examination. His reasons reveal that is what he did.
>
> 25. The assertion in the submissions that Ms Hand's mother travelled with her to the appointment is not the subject of evidence nor any application to admit fresh evidence. Any fresh evidence going to that matter would not have been admissible in any event. In *Petrovic v BC Serv No 14 Pty Limited* Hoeben J held that "*additional relevant information*" did not include material going to the process of the examination by the AMS. The decision was followed by Smart AJ in *Robertson v Registrar of the Workers Compensation Commission & Beny's Joinery Pty Ltd.*

The MAP also held that the AMS' assessment is consistent with other medical reports and the improvement in the appellant's condition that was observed over time. Her statement reveals a significant improvement over the period since psychological treatment ceased in late-2016. While it noted the appellant's preference for a support person when travelling to unfamiliar areas, this indicates only that this makes her more comfortable and not that it is required – "*indicative of the anxiety, a symptoms not an impairment, noted by the AMS.*"

The MAP found that the class 1 assessment for travel was open to the AMS and it stated (citations excluded):

> 41. In *Parker v Select Civil Pty Limited* Harrison AsJ said:
>
>> To find an error in the statutory sense, the Appeal Panel's task was to determine whether the AMS had incorrectly applied the relevant Guidelines including the PIRS Guidelines issued by WorkCover. Even though the descriptors in Class 3 are examples not intended to be exclusive and are subject to variables outlined earlier, the AMS applied Class 3. The Appeal Panel determined that the AMS had erred in assessing Class 3 because the proper application of the Class 2 mild impairment is the more appropriate one on the history taken by the AMS and the available evidence.
>>
>> The AMS took the history from Mr Parker and conducted a medical assessment, the significance or otherwise of matters raised in the consultation is very much a matter for his assessment. It is my view that whether the findings fell into Class 2 or Class 3 is a difference of opinion about which reasonable minds may differ. Whether Class 2 in the Appeal Panel's opinion is more appropriate does not suggest that the AMS applied incorrect criteria contained in Class 3 of the PIRS. Nor does the AMS's reasons disclose a demonstrable error. The material before the AMS, and his findings supports his determination that Mr Parker has a Class 3 rating assessment for impairment for self-care and hygiene, that is to say, a moderate impairment of self-care and hygiene.
>
> 42. That statement is apposite in this case. The AMS obtained a history from Ms Hand as to her ability to drive and attend the appointment by herself. He assessed Ms Hand in class 1 for travel which was an appropriate exercise of his clinical judgement on the basis of the history he obtained, and the relevant information in the documentation.

Accordingly, the MAP confirmed the MAC.

WCC – Arbitrator Decisions

Section 11A WCA – Employer's actions in relation to performance appraisal were not reasonable

McKell v Woolworths Limited [2019] NSWWCC 379 – Arbitrator Batchelor – 28 November 2019

On 1 September 2014, the worker alleged that he suffered a psychological injury as a result of bullying and intimidation during a performance review by the respondent. He alleged that he was "blindsided with an unfair review leaving me feeling bullied, psychologically intimidated and void of any confidence". He ceased work on 17 September 2014. He claimed compensation but the respondent disputed the claim under s 11A *WCA*

In 2017, the worker filed an ARD, but he discontinued those proceedings on 27 June 2017. A COD – Consent Orders included a notation that without admission of liability, the respondent agreed to pay s 60 expenses of up to $8,000.

In the current proceedings, the issues for determination were: (1) whether the worker's psychological injury was wholly or predominantly caused by reasonable action taken or proposed to be taken by or on behalf of the respondent with respect to performance appraisal? and (2) what is the degree of incapacity suffered by the worker as a result of psychological injury arising out of or in the course of his employment with the respondent?

Arbitrator Batchelor conducted an arbitration on 17 September 2019 and 31 October 2019. The parties agreed that PIAWE is $2,439.69, subject to the relevant weekly maximum amount under s 34 *WCA.*

The worker argued that the respondent failed to alert him to the areas in which he was not meeting its required standard, as there was no setting of objectives or goals at the outset. From the time of his new manager's arrival in early 2014, he did not receive any notification of performance matters that required attention and there was no timetable for addressing any such matters and the respondent's actions were therefore not reasonable.

In relation to incapacity, the worker argued that he effectively has no capacity for employment on the open labour market and while he is involved in a family business of renting out holiday accommodation, this cannot be considered employment.

The Arbitrator referred to the decision of Geraghty J in *Irwin v director General of School Education*, in which he defined "*performance appraisal*" as "…*somewhat like an examination, not a continuing assessment. Performance appraisal is more like a limited discrete process, with a recognised procedure through which the parties move in order to establish an employee's efficiency and performance.*" He stated, relevantly:

> 99. In my view that process of assessing the applicant's performance by the respondent in this case, essentially through the actions of his Area Manager Rick Lowe, is consistent with the process described in *Irwin*…
>
> 100. In answer to a question put to counsel for the respondent during the arbitration hearing on 17 September 2019, she was not able to specify when the performance appraisal process began and ended. It was however conceded that issues raised at the unannounced visit in March 2014 were factors that were in the performance appraisal process.
>
> 101. In my view the applicant was subject to performance appraisal by the respondent, which took place at the Coffs Harbour meeting in August 2014 and continued until the Taree meeting on 26 August 2014. Section 11A (1) of *the 1987 Act* refers to "…*reasonable action taken or proposed to be taken by or on behalf of the employer with respect to …performance appraisal…*" Therefore, the actions of the employer, principally through Rick Lowe from the first unannounced visit in early 2014, must be considered when determining if they were reasonable.
>
> 102. I think that the unannounced visit by Mr Lowe and Carl Wilmore in March 2014 set the scene for an uneasy relationship between the applicant and Mr Lowe. Mr Lowe was the applicant's new area supervisor, was aware that the applicant had been with the respondent for a long period and was rated as an effective manager until that time. I accept the applicant's evidence that the practice of unannounced store visits by Area Managers was not one that was utilised by the respondent at the time, although it had been in the past. This is corroborated by Mr McKell's evidence that his enquiry revealed that only one other store manager out of 15 or 16 in the area of supervision of Mr Lowe had been the subject of such a visit. The applicant says that he felt under pressure during the visit and said to Mr Lowe at the end of the visit that he felt he had been "*blindsided*" and shown a lack of respect. Although Mr Lowe denies any lack of respect to the applicant, that was his perception.

103. The applicant criticises the lack of any minutes of meetings which Mr Lowe says he had with him after the first visit to the store, or emails drawing attention addressing measurable issues that needed attention. Criticism is also levelled at the vagueness of Mr Lowe's evidence in respect of the applicant's attitude, particularly when Mr Lowe says that the applicant reverted to his "*old ways*" after a perceived period of improvement in his attitude. Further, the audit on which the respondent relied in the performance appraisal is not in evidence. I accept these submissions of the applicant. There is a lack of written evidence of ongoing communication between Mr Lowe drawing the applicant's attention to shortcomings that needed to be addressed, and to matters in the audit that were substandard.

104. The applicant submits that there is no evidence of "*a number of ongoing, open and constructive discussions throughout the year*" which are referred to in the respondent's "*How this guide will help you*" document as important in respect of a performance review. I accept this, and that there is no evidence of a "*high level of trust*" (also referred to in that document) which was developed between the applicant and Mr Lowe. Further there is no evidence of "*Honest feedback*" about how the applicant had performed compared to others, another matter referred to in the document…

106. The applicant is particularly critical of how he was placed on the bell curve as "*Performance Improvement Required*" when until the visit of Mr Lowe to the store in March 2014 he was rated as effective, which should have placed him in the top 60% on that curve. As I understand the submission, it is the arbitrary nature of the classification of persons on that curve which is unfair in that there must be persons placed in each category, from "*Unsatisfactory Performance*" to "*Effective Performance*". I accept this submission. There was no evidence placed before the Commission which would enable consideration if the classification was reasonable in the circumstances.

107. I accept the applicant's submission that Mr Lowe came to the performance review meeting in Coffs Harbour (the first meeting) with the predetermined outcome that the applicant required performance improvement. This is against a background of a failure on the part of Mr Lowe to properly communicate with the applicant about concerns he had with the applicant's store or his performance by way of emails, or other correspondence or documents to convey to the applicant the areas where improvement was required.

108. The applicant was surprised when, at the Coffs Harbour meeting, he was presented with the fact that he required PIR (Performance Improvement Required). Mr Lowe was apprehensive about the meeting because the applicant was to be presented with this, and although he says that it is not normal to have a third party at such meetings, if he felt that if there was going to be some issue to be discussed, he would bring along such a person. There was a serious issue to be discussed and I think that he should have brought along a third party. For the same reason the applicant should have been given the opportunity to bring along a support person. For the first time in Mr McKell's long employment history with the respondent he was to be presented with an adverse assessment.

109. I think that it was not appropriate to forward to the applicant after that meeting the blank PIP Review document for filling out. Mr McKell was surprised when he received it; he thought that it was odd that he had to fill out a form with his own improvement notes, and the process was that Mr Lowe was to fill out the form for him to sign off on it. Mr Lowe acknowledges this but did not see any issues with someone being offered the opportunity to provide input. This was not foreshadowed of the Coffs Harbour meeting. In view of the applicant's surprise at being confronted with

an adverse review at that meeting, it should have been if Mr Lowe was intending to follow this unusual procedure.

110. The second meeting in Taree on 26 August 2014 was short. Mr Lowe started to go through his points with the applicant, and firstly says at [40] in his statement dated 12 March 2015 that at no point did the applicant's body language suggest that he was disgruntled. He then goes on to say that after approximately 10 minutes he said he felt it best that they cease the meeting as he needed to seek advice from the State HR Manager. His observations of the applicant were that he was disgruntled and trying to be awkward. Mr Lowe says that in hindsight he "*probably should have had HR at the meeting.*" The applicant also should have been given an opportunity to have a support person at the meeting.

The Arbitrator noted that the respondent acknowledged that it was subject to the standards set by the Federal Fair Work Ombudsman in respect of managing underperformance and setting up a performance system checklist. He noted that documents (which are on the public record) setting out the steps to be taken in respect of these matters, indicated that the respondent had not complied with several of those steps, particularly: (a) identifying the issue; (b) assessing the issue; (c) letting the employee know in advance what the discussion will be about and allowing the employee to bring a support person; (d) jointly devise a solution; (e) monitor performance, and (f) keep records.

The Arbitrator held that the worker was subject to performance appraisal over the period from early August 2014 to and including 26 August 2014, and the worker's injury was wholly or predominantly caused by the respondent's actions. However, the respondent's actions were not reasonable.

In relation to incapacity, the Arbitrator noted that the worker had been paid weekly payments for 88 weeks and that s 37 *WCA* applies. He noted that the worker was employed by the respondent for approximately 20 years and that there was no dispute that he could not return to his pre-injury employment with the respondent or another employer. He held that the worker has no capacity for suitable employment and he award continuing weekly payments from 9 May 2017, at the rate of $1,951.75 per week, under s 37 (1) *WCA.* He also made a general order for payment of s 60 expenses and he remitted the s 66 dispute to the Registrar for referral to an AMS.

Section 9AA (3) (c) WCA – Principal working outside Australia for 50% of the time is held to be entitled to compensation under the NSW scheme because the respondent's principal place of business was in NSW

Duff v Helicopter Aerial Surveys Pty Ltd [2019] NSWWCC 382 – Arbitrator Bell – 2 December 2019

The applicant lived in Queensland before being employed by the respondent, after which he spent approximately 50% of his time overseas for the business' purpose of running a fleet of helicopters to spot fish in the commercial fisheries of Micronesia. He was paid in US dollars by way of a transfer to the Bank of Guam. The respondent's postal address was in Sutherland NSW. On 5 January 2015, he suffered injury (which is not described in the decision) and he claimed weekly compensation and s 60 expenses.

On 7 January 2015, the respondent obtained a private ruling from WorkCover NSW under s 175C *WCA,* that the applicant was a worker because: he was engaged by the respondent for a 12-month contract; he was employed and managed by the respondent's Sydney office; he was paid a fixed monthly salary and was required to work fixed hours; and he was entitled to annual leave.

WorkCover NSW also decided that the respondent's principal place of business was in NSW and that NSW is the State of connection for the purposes of s 9AA *WCA* and that a NSW workers compensation policy was required.

However, on 4 July 2018, the insurer denied the claim on the basis that his employment was not connected with New South Wales, but it did not dispute the allegation of injury or the individual claims.

Arbitrator Bell conducted an arbitration hearing on 4 November 2019. The issue for determination was whether the applicant was engaged in employment connected with New South Wales at the time of the incident causing injury on 5 January 2015 (s 9AA (3) *WCA*).

Section 9AA (3) *WCA* provides:

> (1) Compensation under this Act is only payable in respect of employment that is connected with this State.
>
> (2) The fact that a worker is outside this State when the injury happens does not prevent compensation being payable under this Act in respect of employment that is connected with this State.
>
> (3) A worker's employment is connected with:
>
>> (a) the State in which the worker usually works in that employment, or
>>
>> (b) if no State or no one State is identified by paragraph (a), the State in which the worker is usually based for the purposes of that employment, or
>>
>> (c) if no State or no one State is identified by paragraph (a) or (b), the State in which the employer's principal place of business in Australia is located.

The Arbitrator noted that the dispute concerned ss (3) (c) *WCA* and that the respondent disputed that its principal place of business was in New South Wales. He noted that in *Martin v R J Hibbens Pty Ltd,* Roche DP held that "*principal place of business*" means "*chief, most important or main place of business from where the employer conducts most or the chief part of its business*". That is not necessarily the same as a business address registered with ASIC.

Further, in *Workers Compensation Nominal Insurer v O'Donohue*, Roche DP emphasised that it is important to note that the wording of ss 3 (c) is directed at the employer's principal place of business in Australia and it is irrelevant whether it conducts business or has a registered office overseas.

The Arbitrator found that the evidence established that the respondent's principal place of business in Australia was in NSW at the time of injury. The relevant factors were: (a) The business post office box is located at Sutherland NSW; (b) the director lives at Woronora NSW, which is also the business "base"; (c) The activities taking place in NSW include banking receipts and payments, accounting, bookkeeping, invoicing, taxation, and personnel management; and (d) The ASIC registered office is designated to be at the business's accountant nearby at Penshurst NSW. This satisfies the test in *Martin* in which Roche DP cited *Tamboritha Consultants Pty Ltd v Knight* [2008] WADC 78. He stated:

> 23. The respondent submits that the applicant has not discharged the onus of proof as to NSW being its principal place of business in Australia. It is submitted that it is not known whether the employer has an office near to the post office at Sutherland or how often the box is emptied. In my view the frequency at which the post office box is emptied is irrelevant. It is clear the business has a small management business in the modern days of email and other means of internet communication.

24. The respondent submits that Mr Jones does not say he runs the business from Woronora. However, it is an easy inference to draw from the materials, including correspondence and an unrelated claim form that the address is the practical place of business in Australia, with landline phone and facsimile contact.

25. The respondent submits it is significant that all the helicopter work is done overseas and there is no evidence of helicopter work in NSW. However, this is irrelevant to the issue as to a place of business in NSW. There is no requirement that there be helicopter operations within NSW in order for the respondent to have a place of business there.

26. The respondent submits the registered address with ASIC at the office of the respondent's accountant at Penshurst NSW is not conclusive. I agree, but this is nevertheless useful as a factor consistent with the other evidence.

27. The nature of the business in NSW is the conduct of the administrative and financial side as well as employment and operational matters. That the helicopter work is all outside Australia and some administrative tasks are conducted in Micronesia is not relevant for the purposes of the section.

28. As the respondent submits, the WorkCover private rulings are not in any way conclusive or binding, yet the correspondence about these rulings is useful for background information relevant to establishing whether there was a place of business in NSW.

29. There is enough evidence to establish that the Australian principal place of business of the respondent is at Sydney. There is no evidence of a place of business in any other Australian state. It can be inferred that the information given to WorkCover in 2011 and 2013 by Mr Jones about other employees was essentially the same as was provided to them in January 2015 about Mr Duff's status

30. Presumably, as the respondent sought to deny the claim on the basis of s 9AA (3) (c), had there been evidence from Mr Jones as Director or from elsewhere which contradicts the body of material provided by him about the operation of the business it would have been relied on. The investigator for the insurer has made enquiries of Mr Jones and Mr Duff, but there is little or nothing to contradict the evidence supporting the existence of a place of business in NSW.

31. The respondent relies on paperwork from Micronesia including the records of a bank account at the Bank of Guam in the unregistered business name of Tropic Helicopters, and a certificate of the Philippines Aviation Authority showing an address for the respondent at Pomphai, not Sydney. This is not relevant to the issue to be determined. That there is an office in Micronesia is not salient for the purposes of the section.

32. In any case, the document from the Bank of Guam shows a transfer of funds and is addressed to Tropic Helicopters at the post office box at Sutherland NSW. This is the alternative business name used by the respondent in Micronesia (see pp 38 and 44 of the annexures to the respondent's Application to Admit Late Documents). I note that Mr Jones uses that name in his email address. The "*originating party*" for that bank transaction is the respondent with the address shown as Mr Jones' address at Woronora. This document is consistent with what Mr Jones told Ms Edwards, the investigator, in his email to her of 28 May 2015 as to transfers of money from Sydney.

33. I note that Mr Jones is Director of the respondent and it is his own prudent efforts to establish the business's compensation insurance position that provides the basis for the conclusion that the Australian principal place of business of the respondent is at Sydney. It is hardly surprising that in some of the correspondence that Mr Jones appears somewhat bemused by the course of events since the claim by Mr Duff.

> 34. As noted above, there is no evidence of a place of business in any other Australian state. In these circumstances there need only be a place of business in NSW for it to be at the same time the principal place of business in Australia. I find for the above reasons that Mr Duff's employment with the respondent was connected with NSW at the time of injury pursuant to s 9AA (3) (c) of *the 1987 Act*.

Accordingly, the Arbitrator awarded the applicant weekly compensation based upon an updated wages schedule that he filed, although he allowed the parties liberty to apply in relation to that claim, and s 60 expenses.

MVA in 2009 – s 66 claim for multiple injuries including alleged injury to the brain – Cerebral aneurysm suffered approx. 6 months after MVA – whether the alleged brain injury led to the subsequent ruptured aneurysm and intracranial bleeding? – Held: loss of consciousness established a brain injury and its consequences are matters of "medical causation" and should be decided by an AMS – Bindah v Carter Hold Harvey Wood Products Australia Pty Ltd applied.

Yates v NSW Rural Fire Service Association Incorporated [2019] NSWWCC 385 – Arbitrator Dalley – 3 December 2019

On 21 May 2009, the worker was injured in a MVA at work when her vehicle left the road and collided with a tree. She suffered compression fractures in her thoracic and lumbar spines. She attempted to return to work in November 2009, but after 2 hours she suffered a severe headache and vomited. She was taken to hospital by ambulance and was diagnosed with a ruptured cerebral aneurysm, which required surgery

In May 2011, the worker entered into a complying agreement and received compensation under s 66 *WCA* for 24% WPI with respect to the thoracic and lumbar spines.

In January 2012, the worker's position was made redundant and she was offered redeployment at a more junior level, which she declined. She found alternative work with another employer but continued to suffer back pain and impaired cognition and memory.

In February 2018, the worker's solicitors qualified Dr Milder who assessed 5% WPI (cervical spine), 15% WPI (thoracic spine), 12% WPI (lumbar spine) and 15% WPI (mental state). They gave notice of a claim under s 66 *WCA* based upon those assessments, but the insurer disputed the alleged brain injury. The worker filed an ARD and the parties agreed that the following questions should be referred to an AMS by way of a general medical dispute: (1) did the worker receive an injury to her brain in the MVA in 2009? And (2) did the MVA cause or result in an aggravation, acceleration, exacerbation or deterioration of a basilar artery aneurysm?

On 2 August 2019, Dr Mellick issued a MAC that addressed those questions. He opined that there was no historical or radiological evidence or an examination establishing a brain injury that occurred at the time of the MVA. He also opined that the MVA did not result in the aggravation, acceleration, exacerbation or deterioration of the basilar aneurysm and the MVA could not be considered a main contributing factor to its rupture.

However, ***Arbitrator Dalley*** determined that the worker did suffer an injury to her brain as a result of the MVA and that its effects are matters to be determined by an AMS as these are matters of medical causation. He stated:

> 116. I base this reasoning upon the analysis of the respective roles of the Arbitrator and the AMS to be found in the judgement of Emmett JA in *Bindah v Carter Holt Harvey Wood Products Australia Pty Ltd:*
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> > [109] However, that is not to say that there is no scope for an approved medical specialist or Appeal Panel to make findings of fact necessary for the performance of the function that they are given under the Management Act. Questions of causation are not foreign to medical disputes within the meaning

of that term when used in the Management Act. A medical dispute is a dispute about or a question about any of the matters set out in s 319. Those matters include the degree of permanent impairment of a worker as a result of an injury, and whether any proportion of permanent impairment is due to any previous injury or pre-existing condition or abnormality. The words in bold in relation to each of those matters call for a determination of a causal connection. Thus, the language of causal connection is squarely within the definition of "*medical dispute*". Having regard to the conclusive effect of s 326, it is desirable to avoid drawing a rigid distinction between jurisdiction to decide issues of liability and jurisdiction to decide medical issues. There is no bright line delineating causation from medical evidence. Issues of causation may well involve disputes between medical experts that must be resolved by an approved medical specialist or by an Appeal Panel (see *Zanardo v Tolevski* [2013] NSWCA 449 at [35])…

120. With respect to the issue of whether Mrs Yates suffered an injury to the brain in the course of the subject accident I accept the evidence of Mrs Yates that she lost consciousness as result of the impact of her vehicle with an obstacle in the light of the evidence of the witness, Mr Ross Chapman…

125. I prefer the evidence of Mr Chapman to the effect that Mrs Yates was unconscious when he approached her vehicle. The likelihood of this is supported by the fact that it was Mr Chapman who located Mrs Yates's mobile phone and telephoned her husband to inform him of the accident. I am satisfied on the balance of probabilities that Mrs Yates did in fact lose consciousness at the point of impact.

126. I have considered the opinion of the AMS. The AMS does not give a reason why he regards the aneurysm as having been present "*long before the motor vehicle accident*." The AMS refers to the MRI scan of the brain which he states was carried out on 7 February 2007. If the AMS accepted that this was the actual date when the scan was performed then this would explain his positive statement that the aneurysm pre-existed the subject accident.

127. In reaching the conclusion that there was no evidence; "*historically or radiologically or on examination establishing a brain injury to have occurred at the time of the motor vehicle accident*" the AMS does not appear to have considered the issue of whether Mrs Yates lost consciousness upon impact, but rather addressed the wider question of whether the subject accident is causally related to the subsequent intracranial bleeding.

128. The AMS notes the opinion of Professor Kiernan and agrees that there is no aetiological connection between the rupture of the aneurysm and the subject accident but this does not address the question of whether there was an injurious impact on the brain causing loss of consciousness at the time of the subject accident.

129. Professor Kiernan accepts that it is "*likely from the description provided by Mrs Yates that there was a period of loss of consciousness related to the subject accident*". He added that there was "*no objective evidence of structural abnormality on brain imaging to suggest that Mrs Yates suffered a traumatic brain injury*." That latter observation does not account for the loss of consciousness which would appear to flow from the impact due to the mechanism described by Associate Professor Raftos.

130. I accept the opinion of Associate Professor Raftos that loss of consciousness is evidence of injury to the brain in the manner that he describes in detail in his report. I make no finding with respect to whether that injury is causally connected to the subsequent intracranial bleeding, this being a matter for the AMS.

Accordingly, the Arbitrator remitted the matter to the Registrar for referral to an AMS to assess the degree of whole person impairment of the cervical, thoracic and lumbar spines and the brain as a result of the MVA in 2009.

WCC – Registrar's Decisions

Section 39 WCA – Application for assessment by an AMS – No dispute that maximum medical improvement not reached – Held: Worker did not make a claim for compensation and there is no medical dispute – Application dismissed

Weate v Racing NSW [2019] NSWWCC 397 – Arbitrator Batchelor – 11 December 2019

The worker was a thoroughbred jockey for 37 years until 15 January 2008, during which he suffered multiple injuries. On 15 January 2018, he had a fall while riding in a barrier trial and suffered fractured ribs and a shoulder injury, after which he was not cleared to return to riding. He returned to work as a cleaner for 16 hours per week.

On 17 November 2009, Dr Bodel (AMS) issued a MAC that assessed 6% WPI (right upper extremity) as a result of the fall on 15 January 2008 and 7% WPI with respect to the lumbar spine (injury due to the nature and conditions of employment – deemed date: 15 January 2008).

Immediately before 1 October 2012, the worker was an existing recipient of weekly payments as defined in cl 1 of Div 1, Pt 19H of Sch 6 *WCA*. On 17 August 2017, the respondent issued a s 39 *WCA* notice to the worker, advising that his weekly payments would cease on 26 December 2017.

In January 2018, Dr Sharp, orthopaedic surgeon, diagnosed a fracture of the acromion and marked osteoarthritis and displacement of the right shoulder. On 19 April 2018, he sought approval for surgery from the respondent. However, the respondent qualified Dr Smith, who opined that there was no relationship between the arthritis condition and the fall on 15 January 2008, and it disputed the claim.

The worker filed an ARD and on 11 April 2019, a COD – Consent Orders noted that without prejudice and without admission of liability, under ss 41A and 50(2) *WIMA*, the respondent agreed to pay the costs of and incidental to the proposed right shoulder surgery. Dr Sharp performed that surgery on 22 May 2019 and on 1 July 2019, he reported that maximum medical improvement had not been reached.

On 17 July 2019, the worker solicitors wrote to the respondent, serving Dr Sharp's report and requesting that their letter "*be treated as a claim for resumption of weekly payments and reconsideration by the insurer in relation to resumption of such weekly payments based on the worker not having reached maximum medical improvement as it is not ascertainable directly after surgery*". It foreshadowed an application to the Commission unless a response was received within 7 days.

On 7 August 2019, the current application was filed with the Commission. The worker sought an assessment as to whether the degree of permanent impairment was fully ascertainable under s 319 (g) *WIMA.*

On 23 August 2019, the respondent's solicitor wrote to the worker's solicitor, confirming that there is no dispute that maximum medical improvement is not ascertainable as at the date of Dr Sharp's report and as there was no dispute, there was no requirement for referral to the Commission.

Arbitrator Batchelor conducted an arbitration on 19 November 2019. He identified the following issues for determination:

(1) Has a claim for compensation of any kind been made such as to give the Commission jurisdiction in the matter?

(2) Is there a valid claim to be sent to the AMS in response to the Application?

(3) Does the Act allow for the claim to be referred to an AMS based on the applicant not having reached maximum medical improvement?

The Arbitrator held that no claim for compensation had been made. He noted that the worker argued that as the respondent had not resumed payment of weekly benefits, there is a "*medical dispute*" as defined in s 319 (g) *WIMA* about whether the degree of permanent impairment is fully ascertainable or a question to that effect.

However, the respondent conceded that the worker had not reached maximum medical improvement as at 1 July 2019, and argued that the appropriate course for the worker to take would have been to wait a further two or three months (or longer, as suggested by Dr Sharp) in order to reach maximum medical improvement, seek a WPI assessment and then make a claim on it under s 66 *WCA* – assuming that the WPI assessment was greater than 10%. If it disputed the quantum of the WPI claimed, the matter would then be referred to an AMS. If the AMS declined to make an assessment because they were of the opinion that the degree of permanent impairment was not fully ascertainable because maximum medical improvement had not been reached, could then obtain the benefit of the definitions of a worker with high or highest needs in s 32A *WCA.* In that circumstance, an assessment would be "*pending*" as referred to in (b) of the definitions of workers with high and highest needs.

The Arbitrator stated, relevantly:

> 64. The applicant has chosen not to pursue that course, but to seek referral of his matter for assessment by an AMS in the absence of supporting evidence that maximum medical improvement had been reached and therefore in the absence of a claim for compensation for permanent impairment. The respondent submits that this is a "*back door*" approach, and an abuse of process, noting that even claims for permanent impairment resulting from the most minor of injuries would enable an injured worker to obtain, for a period, weekly and other benefits to which he or she would not be entitled once the degree of permanent impairment resulting from the injury was assessed by an AMS. I think that there is merit in this submission.
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> 65. More importantly I do not think that the applicant's letter to the respondent dated 17 July 2019 is a claim for compensation. The definitions of "*claim*" and "*compensation*" are referred to above at [53]. I do not think that the letter, notwithstanding the claim for the resumption of weekly payments referred to in the third paragraph thereof, is a claim for compensation. The terms of the applicant's claim for the commencement of weekly compensation are fully set out at [55] above. The claim is framed in terms of the definitions of a worker with high or highest needs in s 32A, and with reference to s 39.
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> 66. Section 39 (2) states that the section does not apply to an injured worker whose injury results in permanent impairment if the degree of permanent from the injury is more than 20%. The applicant satisfies the first of these requirements but not the second. Dr Bodel assessed Mr Weate as having sustained 6% WPI as a result of injury to his right shoulder on 15 January 2008. The Note to subsection (2) states that for workers with more than 20% permanent impairment, entitlement to compensation may continue after 260 weeks but entitlement after 260 weeks is still subject to s 38.

67. There is no reference in s 39 to a worker with high or highest needs, nor is there reference to an injured worker having reached maximum medical improvement. It is a section that was inserted in *the 1987 Act* in 2012 to limit the entitlement of injured workers to weekly benefits, subject to the condition referred to in subsection (2).

68. What the applicant is claiming in the letter of 17 July 2019, confirmed by his lodgement of a Form 7, is referral of the matter to an AMS for assessment as to whether the degree of permanent impairment is fully ascertainable. That course of action was adopted by the applicant in the knowledge that as at 1 July 2019 the degree of permanent impairment was not fully ascertainable because maximum medical improvement had not been reached but that it would probably be reached in two or three months, although it could be longer. There was a concession from the respondent, albeit after lodgement of the Application, that as at 1 July 2019 that maximum medical improvement was not ascertainable.

69. If perchance the applicant would have been successful in having the matter referred to an AMS in response to the Application and the AMS had declined to make an assessment on the basis that the degree of permanent impairment was not fully ascertainable, that would still not entitle the applicant to weekly benefits beyond 260 weeks. In terms of s 39, he would still not be a worker whose injury resulted in permanent impairment of more than 20%. Pending assessment of the degree of permanent impairment when maximum medical improvement was reached, he would be a worker with high or (as the applicant submits in this case) highest needs. He may be entitled to other benefits under the 1987 Act, for example under s 59A, but not to weekly benefits.

70. There is reference to a worker with high needs in s 38 of *the 1987 Act* which specifies special requirements for continuation of weekly benefits after the second entitlement period of 130 weeks referred to in s 37. Section 38A makes special provision for workers with highest needs. However the applicant still needs to satisfy s 39 (2) for him to have an entitlement to weekly payments of compensation after an aggregate period of 260 weeks.

The Arbitrator dismissed the application as it sought an assessment as to whether the degree of permanent impairment was fully ascertainable and there was no medical dispute.

FROM THE WIRO

The WIRO team wish you all the best for the festive season and a happy and safe new year.