Bulletin
Issue No. 89

Independent Review Office

RECENT CASES

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

Decisions reported in this issue

1. Collins v Dux Manufacturing Ltd [2021] NSWSC 193
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Supreme Court of NSW – Judicial Review Decisions

A delegate of the Registrar of the Workers Compensation Commission determined several proposed grounds of appeal to a MAP on a final and conclusory basis – Error of law conceded - Decision quashed

Collins v Dux Manufacturing Ltd [2021] NSWSC 193 – Harrison AsJ – 2/03/2021

On 22/08/2017, the plaintiff suffered a work-related psychological injury. She claimed compensation under s 66 *WCA* based upon an opinion from Dr Rastogi, who assessed 19% WPI as a result of the injury. However, the insurer disputed the claim based upon an opinion from Dr Synnott, who assessed 5% WPI.

The dispute was referred to an AMS and on 10/03/2020, Professor N Glozier issued a MAC which assessed 8% WPI.

On 7/04/2020, the plaintiff lodged an Application to Appeal the MAC under ss 327 (3) (c) and (d) *WIMA*, on the following grounds:

> (1) The AMS's explanation and reasoning as to the appropriate class in respect of social functioning ought to have resulted in the assigning of class 3 representing moderate impairment rather than class 2 representing mild impairment. It was submitted that the AMS's reasoning disclosed error, because he expressed disagreement with the assessment by Dr Synnott who gave the plaintiff class 2 for social functioning but then proceeded to assign class 2 for that category ("*the social functioning ground*").
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> (2) The AMS erred because he failed to adjust the impairment rating for the effects of the treatment in accordance with clause 1.32 of the Guidelines ("*the failure to include an adjustment for the effects of treatment ground*").
>
> (3) The AMS erred by assigning class 2 for self-care and personal hygiene in circumstances where the plaintiff is abusing alcohol ("*the self-care and personal hygiene ground*").

On 7/05/2020, a delegate of the Registrar of the Workers Compensation Commission issued a decision.

In relation to ground (1), the delegate did not accept that there is a clear inconsistency in the MAC and that the AMS' findings and conclusions in respect of the appropriate PIRS category were open on the evidence.

In relation to ground (2), the delegate stated:

> 22. The appellant suggests that there is an inconsistency between the AMS's diagnosis and his failure to make an allowance under clause 1.32 of the Guidelines. Firstly, the provision of a diagnosis is a step within the assessment process and plays an important role within the assessment of psychiatric injuries (see clause 11.4 of the Guidelines). That does not mean that a diagnosis of a condition "in partial remission" constitutes a finding consistent with the criteria outlined in clause 1.32 of the Guidelines. The provision of a diagnosis and consideration of the treatment effect are separate criteria and should be considered separately. Secondly, I do not accept that the words "in partial remission" relative to a diagnosis constitute a finding of "substantial or total elimination of the claimant's permanent impairment". The two are not inconsistent or at odds.
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> 23. The appellant further submits that the AMS has not provided adequate reasons. I do not accept this submission. As discussed above, the MAC must be read as a whole. The MAC is thorough and the AMS has considered the appellant's diagnosis at length. Reasons must follow a logical path (*Wingfoot Australia Partners Pty Ltd v Kocak* [2013] HCA 43). The AMS's reasons are logical and clear.

In relation to ground (3), the delegate stated, relevantly:

> 32. The AMS has considered the relevant criteria in reaching his conclusion in this category. He highlights Ms Collins' ability to manage many daily activities, including shopping, cooking and cleaning. He discusses Ms Collins' use of alcohol throughout the MAC, and clearly considers it in his assessment under this category. He was clearly of the view that Ms Collins' issues with alcohol were a relevant consideration (as is, apparently, the appellant), and determined that due to her ability to function in combination with her alcohol abuse, she fell into class 2. This finding was open on the evidence and the AMS's reasons are clear and consistent.
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> …
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> 34. This ground of appeal is in essence a disagreement with the outcome rather than an identification of appealable error. A difference of opinion is not a demonstrable error: *Merza v Registrar of the Workers Compensation Commission and Anor* [2006] NSWSC 939 at [51].

The plaintiff applied to the Supreme Court of NSW for judicial review of the delegate's decision.

Harrison AsJ determined the Summons and noted that the insurer conceded grounds (1) and (2). Her Honour stated, relevantly:

> 42 In relation to appeal ground 1 concerning social functioning, the Delegate stated at paragraph 15, "*I do not accept that there is a 'clear inconsistency' in the MAC*." In addressing appeal ground 2 concerning failure to include adjustment for the effects of treatment, at paragraph 22 the Delegate stated, "*I do not accept that the words 'in partial remission' relative to a diagnosis constitute a finding of 'substantial or total elimination of the claimant's permanent impairment'. The two are not inconsistent or at odds*." At paragraph 23 the Delegate continued, "*The AMS's reasons are logical and clear*." The insurer has conceded that the Delegate erred in his determination in relation to these grounds.
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> 43 As to appeal ground 3 concerning self-care and personal hygiene, at paragraph 32 the Registrar concluded, "*[The AMS] was clearly of the view that Ms Collins' issues with alcohol were a relevant consideration (as is, apparently, the appellant), and determined that due to her ability to function in combination with her alcohol abuse, she fell into class 2. This finding was open on the evidence and the AMS's reasons are clear and consistent*." The Delegate concluded his comments on this ground at paragraph 34, where he stated, "*This ground of appeal is in essence a disagreement with the outcome rather than an identification of appealable error. A difference of opinion is not a demonstrable error*." The insurer has not conceded that the Delegate erred in relation to his reasoning on this ground.

> 44 It is my view that, as in *Ballas*, the Delegate in these proceedings did not express himself in terms of whether the plaintiff's grounds of appeal were capable of, in the sense of having the potential to be, made out. In each of paragraphs 15, 22, 23, 32 and 34 of his decision, the Delegate has overstepped this statutory role as gatekeeper by purporting to finally determining the grounds of appeal. These are jurisdictional errors that cannot be remedied by his conclusion at paragraph 37 which repeated the proper legal test as set out at paragraphs 7 to 9 of his decision.

Accordingly, her Honour quashed the delegate's decision and remitted the matter to the Personal Injury Commission for determination according to law. She ordered that each party should pay its own costs.

Workers compensation insurer does not owe a duty of care to an injured worker

McLaughlin v Employers Mutual NSW Limited [2021] NSWSC 198 – Cavanagh J – 2/03/2021

The plaintiff sustained injuries as a result of a fall at work on/around 16/03/1999 and was further injured at work on 18/06/1999. As a result of these incidents, he injured his cervical spine and left shoulder and also suffered a psychological injury. He also alleged that he injured his back and that he developed a consequential condition of epilepsy. He claimed workers compensation.

The defendant was the employer's workers compensation insurer and it made payments to the plaintiff between 1999 and 2003. There was a dispute between the parties regarding the amount of compensation payable during that period and the plaintiff's fitness for work. The plaintiff complained that he was forced to attend rehabilitation services and was wrongly forced to return to some form of work on the recommendation of the rehabilitation provider.

On 13/12/2002, the dispute between the plaintiff and the employer first came before Commissioner Hogg in the Compensation Court. On 5/09/2003, Hogg C determined that the he was fit for some work but that he was not seeking suitable employment in accordance with his obligations under s 52A *WCA*. The defendant discontinued weekly payments to the plaintiff based upon that judgment. Hogg C found that the plaintiff had not been seeking suitable employment and made no effort whatsoever to seek work within his capabilities.

At some later stage, the plaintiff asked the defendant to review its decision and reinstate weekly payments. The defendant declined to do so, although it did pay a further short period of weekly payments and medical expenses between 2004 and 2005.

Cavanagh J conducted a hearing at which the plaintiff was self-represented. His Honour stated that the plaintiff gave oral evidence, particularly relating to the difficulties that he has experienced over the past 20 years in relation to his health, the very significant issues that have confronted him, and his considerable determination in overcoming the problems that he has had to deal with.

The plaintiff sued the defendant seeking compensation in respect of injuries and losses he has sustained since approximately 1999. He alleged that the defendant owed him a duty of care and had acted in breach of that duty and it had unfairly applied s 52A *WCA*.

The plaintiff accepted that this settlement would bring to an end his rights with respect to the neck injury, but that he was pursuing a separate claim for his back injury and the defendant wrongly declined to pay him any weekly payments or costs of surgery that he requires. He said that he did not wish to pursue a claim for his back when the WIDs claim resolved as it was recommended that he should defer having back surgery for as long as possible.

His Honour noted that the plaintiff disagreed with Hogg C's findings and maintained that he has been severely disabled since the accidents, with the exception of the limited periods in which he tried to go back to work.

His Honour stated that prior to 2008, the plaintiff consulted solicitors regarding a work injury damages claim. On 9/12/2008, those solicitors wrote to the defendant giving notice of a WIDs claim. Pre-filing statements were filed and there was a settlement of the claim, which is reflected

in a Deed of Release dated 2/11/2009. The defendant paid the plaintiff $220,000, clear of past payments and inclusive of costs.

The plaintiff also alleged that although he has been suffering from epilepsy since about 2000, which is related to the accidents, the condition was first diagnosed in 2016 and he has been pursuing a claim against the defendant for that condition. However, the defendant has refused to acknowledge or accept that claim.

In 2016, the plaintiff contacted his solicitors and advised them that he now wished to have back surgery and he requested them to make a claim for the surgery costs against the defendant. However, he was advised that he settled his rights regarding his back injury in 2009 and could not pursue a new claim for that injury. He then contacted the defendant and asked it to pay for the surgery, but it declined to do so. He then contacted a company called Law Access and was advised that he had a right to make a claim in respect of his back injury. He took this issue up with SIRA and WIRO and also spoke to the Police regarding the conduct of his solicitors.

The plaintiff sued his solicitors. However, his Honour noted that Bellew J dismissed those proceedings: *McLaughlin v Burrows & Ors t/as Kells the Lawyers* [2020] NSWSC 1802.

His Honour stated, relevantly:

> 30 In order to move the matter forward, I asked the plaintiff to identify the real nature of his case and what he really sought from the defendant. He identified six, what I will call, failures of the defendant which I will now list being:
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> > (1) During the period 1999 to 2002 the rehabilitation provider forced him to undertake rehabilitation and work when he was not fit to do so and the defendant supported that conduct;
> >
> > (2) During the period 2002 to 2009 the defendant failed to organise rehabilitation for the consequences of his neck injury;
> >
> > (3) From 2009 on the defendant failed in its duty of care to him in that, again, it did not organise any rehabilitation for him, whether in respect of his back or neck injury;
> >
> > (4) The defendant unfairly applied s 52A of the WCA in the sense that it should have reinstated his income payments despite the finding of Commissioner Hogg;
> >
> > (5) The defendant failed to accept the diagnosis of epilepsy and accept that it was liable to make payments to him. Instead, it continued to deny the claim; and
> >
> > (6) There was an underpayment of workers compensation from 1999 to 2003. The plaintiff says that his employer was underpaying him, that it should have been paying him a lot more money and this has resulted in an underpayment from the workers compensation insurer, being the defendant.
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> The defendant argued that:
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> (1) By operation of s 151A *WCA* and the deed of release, the settlement of the WIDs claim in 2009 brought to an end the plaintiff's right to compensation;
>
> (2) There is no causal nexus between, the neck injury and the development of epilepsy;
>
> (3) Section 105 *WIMA* provides that the Personal Injury Commission has exclusive jurisdiction to deal with disputes relating to compensation payments under the *WCA*;
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> (4) The plaintiff's arguments regarding the effect of s 52A *WCA* is misplaced; and
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> (5) The plaintiff has not established that it owes him any duty of care and/or breach of that duty of care.

His Honour stated:

> 36 In my view, there are some fundamental problems for the plaintiff in pursuing the claim that he is pursuing in this Court, both as pleaded and as articulated during the hearing. Those problems include the following.
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> 37 Firstly, neither the plaintiff nor the defendant have been able to identify any case or authority which supports the proposition that a workers compensation insurer in the position of the defendant owes a duty of care to a person employed by one of an insurer's insureds and seeking workers compensation. Indeed, whilst there has been what I will describe as the occasional judgment in which this issue has been considered, I am not aware of any case where there has been a finding that, in the circumstances of the relationship between the defendant and the plaintiff in this matter, the defendant owed a duty of care to the plaintiff.
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> 38 I am not considering whether the defendant owed a duty to act with good faith towards the plaintiff or whether it owed some statutory obligation as set out in either the WCA or the WIM Act. The plaintiff's case as pleaded and as put orally is that the defendant failed to comply with its duty of care. A duty of care is not owed in a vacuum. Whether a duty of care is owed must depend upon the relationship between the parties. There are some common relationships which give rise to duties of care, as are well-known, such as employers and employees, occupiers and entrants, schools and teachers.
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> 39 The defendant was not the employer of the plaintiff. The employer of the plaintiff was High Sierra Windows. The defendant was and is an insurer licensed to provide workers compensation benefits to and on behalf of an employer. The defendant has statutory obligations and obligations to make payments, make a determination and deal with claims as set out in the legislation.
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> 40 In my view, the relationship between the plaintiff and the defendant did not impose on the defendant a duty of care independently of its statutory obligations.
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> 41 Thus, the first problem with the plaintiff's claim is that it is dependent upon acceptance that the defendant owed a duty of care to the plaintiff. In my view, it did not.
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> 42 The second problem with the plaintiff's claim in this Court is that s 105 of the WIM Act states that the Commission has exclusive jurisdiction to examine, hear and determine all matters arising under the WCA (see s 105(1)).
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> 43 This means that in any dispute as to the entitlement of a worker such as the plaintiff to payments from a workers compensation insurer or employer, the proceedings should be commenced in the Commission (now called the Personal Injury Commission) and not in this Court.
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> 44 Although the plaintiff says that he is suing the defendant in negligence and that he wants compensation, including payment of medical expenses, benefits and loss of income, in reality his main complaint is that the defendant has failed to make payments to him for a lengthy period and, in particular, has failed to pay for his medical treatment, including a back operation, and failed to properly respond to his claim in respect of his epilepsy.
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> 45 These are matters which give rise to a dispute between the plaintiff as a worker, his employer and the defendant as the insurer, as to an entitlement to statutory benefits. The Commission has exclusive jurisdiction to determine that dispute. As such, this is not the right place for the plaintiff to be suing the insurer seeking payment of benefits. Section 105 is not an answer to the claim in negligence but, having regard to the way the case was presented, it does seem to me that the plaintiff's real complaint is that the defendant has not responded to his claim for further payments.
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> 46 The third problem with the plaintiff's claim is that even assuming that the insurer owed a duty of care as suggested, the plaintiff's claims are more a description of complaints about conduct than an articulation of a failure to act with care. In any negligence action it is

necessary to articulate not only why a party owes a duty of care but the scope of that duty of care and how the conduct might be said to be a breach of the duty of care.

His Honour held that there is no basis for any allegation in negligence in respect of the defendant's response to his disability in the years following Hogg C's judgment. It is difficult to understand how the defendant could be negligent in failing to accept the claim for the back operation in circumstances where, on the plaintiff's own case, his solicitors told him that he had settled his rights to payment for the back claim in 2009. His Honour concluded:

> 53 The final matter raised by the plaintiff is that the defendant failed to make appropriate payments of compensation back in 1999. As I understand the submission this occurred because his employer had been underpaying him and this resulted in a lesser payment of workers compensation than should have been made. Again, I do not know whether his employer was underpaying him but, if I accept what the plaintiff says, the reason that he was underpaid by the defendant is because the employer had not been paying him the correct salary. Again, that does not give rise to a cause of action by the plaintiff against the defendant.
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> 54 Finally, and although it is not necessary to make any determination on this issue, the conduct said to give rise to underpayment happened 20 years ago. Section 14 of the Limitation Act 1969 (NSW) provides for a limitation period of 6 years. Even if other provisions of the Act such as s 50C apply, it is difficult to anticipate the basis on which those provisions might be overcome.
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> 55 I should say that the plaintiff gave evidence and developed an argument that he was suffering from a mental illness, including depression and anxiety, and he described epilepsy as a mental illness. Even if that may be so (and I am not doubting that) if it became necessary to determine the matter on a limitation point, it may be that there would be some further difficulties for the plaintiff. I do not consider it necessary to make any further comment on the limitation point.
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> 56 In the end the plaintiff must fail. He has not established any cause of action against the defendant. I do not accept that the defendant was negligent as maintained. I do not accept that the defendant owed a duty of care to the plaintiff. To the extent that his claim is really a claim for payments dressed up as a claim for negligence which, to a large degree, it appears to be, then this is not the right forum. If he wishes to pursue a claim with the Personal Injury Commission, that is a matter for him. In the circumstances, the plaintiff fails and there shall be a judgment for the defendant.
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> 57 It is the normal rule in these sorts of cases that costs follow the event. Whilst the plaintiff indicates that he does not wish to pay costs - and whilst I understand that he is self-represented - I am not aware of any circumstances which would lead to a variation of the normal rule here. I order the plaintiff to pay the defendant's costs.

WCC – Medical Appeal Panel Decisions

MAP found evidence of deterioration of the appellant's condition and admitted further relevant information – MAC revoked, and a new MAC issued

Kennewell v ISS Facility Services Australia Limited t/as Sontic Pty Ltd - [2021] NSWWCCMA 40 – Arbitrator Bell, Dr J Bodel & Dr M Burns – 24/02/2021

The background to this matter is summarised as follows. On 2/05/2005, the appellant injured his right arm at work. On 6/05/2015, Dr O'Keefe issued a MAC, which assessed 11% WPI (right upper extremity and scarring (TEMSKI)). On 10/06/2015, the Commission issued a COD and ordered the respondent to pay the appellant compensation under s 66 WCA for 11% WPI. On 6/04/2018, Dr Burrow, AMS, assessed that the appellant to determine whether he was exempt from the operation of s 39 *WCA* and certified that the degree of permanent impairment in respect of the injury to the right upper extremity was not fully ascertainable

On 14/09/2018 and 29/11/2018, Arbitrator Sweeney issued a COD with respect to a claim for retrospective weekly payments under ss 38 and 39 *WCA.* He made an order for retrospective payments. On 21/03/2019, Dr Anderson (the appellant's IME) assessed 26% WPI, but on 17/04/2019, he revised this assessment to 28% WPI.

On 6/12/2019, the appellant lodged a Miscellaneous Application seeking a reconsideration of the COD dated 10/06/2015. For the purpose of a referral of the matter for further medical assessment or reconsideration under s 329 *WIMA.* On 13/03/2020, Arbitrator Read issued a COD that revoked the COD dated 10/06/2015 under s 350 WIMA, but he declined to refer the matter to an AMS for further assessment or reconsideration.

On 24/03/2020, the appellant appealed against the MAC under ss 327 (3) (a) and (b) *WIMA.*

Following a preliminary review, the MAP determined that it was necessary for the appellant to be re-examined and on 26/10/2020, Dr Bodel re-examined the appellant on behalf of the MAP.

The appellant sought to rely upon further evidence, including numerous letters from his GP to Dr English (treating surgeon), a medical certificate issued by Dr English in December 2018, Dr Burrow's MAC dated 6/04/2018 and Dr Anderson's reports. The respondent conceded that the further surgery that the appellant underwent to his right shoulder in December 2017 is further relevant medical evidence that was not available to the AMS at the time of his assessment in 2015. The MAP determined that the appellant's further evidence should be accepted in the appeal.

The MAP accepted the assessment by Dr Bodel, who assessed 18% WPI as a result of the injury. He did not apply a deductible under s 323 *WIMA.* Accordingly, it issued a fresh MAC which assessed 18% WPI.

WCC – Arbitrator Decisions

Worker entitled to one further assessment of permanent impairment by an AMS in accordance with Pt 2A of Sch 8 of the 2016 Regulation

Mani v Australian Pharmaceutical Industries Ltd [2021] NSWWCC 63 – Senior Arbitrator Capel – 24/02/2021

On 16/04/2009, the worker injured his knees a result of a fall that occurred while he was on the way to work. He ceased work in July 2009.

In 2011 and 2016, the worker commenced WCC proceedings claiming compensation under s 66 WCA and both disputes were referred to Dr McGroder.

On 29/11/2011, the AMS issued a MAC which assessed 20% WPI (2% WPI (right lower extremity) and 18% WPI (left lower extremity)). On 31/01/2012, the Commission issued a COD based upon that MAC.

On 1/07/2016, Dr McGroder issued a further MAC which was in the same terms as the 2011 MAC and he assessed 0% WPI for scarring. On 15/12/2016, the Commission issued a COD which determined that the worker had no further entitlement to lump sum compensation.

The worker appealed against the 2016 MAC and on 10/11/2016, the MAP confirmed the COD. On 3/12/2016, the Commission issued a further COD which determined that the worker had no further entitlement to lump sum compensation.

On 30/04/2018, the worker filed an Application for Assessment by an AMS and the matter was referred to Dr McGroder to assess whether the degree of permanent impairment was fully ascertainable in accordance with s 319 (g) *WIMA.* However, the AMS was requested to refrain from assessing the degree of permanent impairment if it was in fact fully ascertainable.

On 30/05/2018, Dr McGroder issued a MAC which certified that the applicant's right knee injury had not reached maximum medical improvement as surgery was anticipated.

On 11/03/2019, the respondent filed an Application seeking an assessment as to whether the degree of permanent impairment was more than 20% for the purposes of s 319 (c) *WIMA.* The applicant opposed this referral because this would represent his one further assessment for the purposes of cl 28D of Sch 8 of the Regulation and s 322A (1) *WIMA.*

On 24/05/2019, Dr McGroder stated that the right knee injury had not reached maximum medical improvement as the worker was having revisionary surgery.

The respondent qualified Dr Powell and on 7/04/2020, he stated that maximum medical improvement had been reached and he assessed 20% WPI (2% (right lower extremity) and 18% WPI (left lower extremity) but 0% WPI for scarring).

On 19/05/2020, the respondent requested that the matter be referred back to Dr McGroder for reconsideration of the 2019 MAC under ss 329 (1A) and 350 (3) *WIMA*. The worker agreed to this referral.

However, on 9/06/2020, a delegate of the Registrar determined that a further assessment of permanent impairment was not available to the worker, but he was entitled to be referred back to the AMS to determine whether the degree of permanent impairment was fully ascertainable. He directed that the matter be referred to Dr McGroder for reconsideration under s 319 (g) *WIMA.*

The worker's solicitor qualified Dr Dias, who certified that maximum medical improvement had been reached and he assessed 24% WPI (right lower extremity), 18% WPI (left lower extremity) and 1% WPI (scarring).

On 25/08/2020, Dr McGroder issued a MAC which certified that the degree of permanent impairment was fully ascertainable.

On 2/09/2020, the insurer advised the worker that his weekly payments would cease on 6/10/2020 under s 39 *WCA,* based upon Dr Powell's assessment of 20% WPI.

On 14/09/2020, the worker requested that the matter be referred back to Dr McGroder under ss 329 (1A) and 350 (3) *WIMA*, for reconsideration and assessments of permanent impairment of both lower extremities and scarring. However, the respondent opposed that application and the worker did not press the application for reconsideration.

On 19/11/2020, the worker applied for an assessment by an AMS as to whether the degree of permanent impairment exceeds 20% WPI for the purposes of s 39 *WCA.*

Senior Arbitrator Capel held that it is necessary to look at the text, language and structure of the legislation, the legal and historical context and the purpose of the statute in order to come to a reasonable conclusion regarding the meaning and application of cl 11 and Pt 2A of Sch 8 of *the 2016 Regulation* and their interaction with s 322A *WIMA.* After discussing the relevant caselaw, he stated, relevantly:

> 87. In this matter, there is no dispute that the applicant had his one further assessment of impairment for the purposes of cl 11(2) of Pt 1 of Sch 8 of *the 2016 Regulation* on 1 July 2016.
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> 88. The assessments undertaken by the AMS in May 2018 and May 2019 were undertaken with the view of determining whether the applicant's permanent impairment was fully ascertainable in accordance with s 319 (g) of *the 1998 Act*. They did not concern an assessment of the degree of permanent impairment in accordance with s 319 (c) of *the 1998 Act*.
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> 89. The email from the Registrar dated 3 May 2019 explained that the respondent sought an assessment pursuant to s 319 (c) of *the 1998 Act*, which was opposed by the applicant. The Registrar advised that the referral was instead made pursuant to s 319 (g) of *the 1998 Act* in order to preserve the applicant's entitlement to one further assessment of the degree of permanent impairment. The MAC that issued in August 2020 was in respect of a referral in accordance with s 319 (g) of *the 1998 Act*.

90. In the decision dated 9 June 2020, the Delegate of the Registrar stated that "*based on the submissions attached to the Response, as outlined above, a further assessment of permanent impairment is not available to Mr Mani and that question appears irrelevant for an independent medical expert to answer.*"

91. The Delegate did not provide any detailed reasons why he came to that conclusion other than it was based on the employer's submissions. His decision is also at odds with the Registrar's email dated 3 May 2019. I do not agree with the Delegate's reasoning.

92. Given the restriction provided in cl 28D (2) of Sch 8 of *the 2016 Regulation* regarding the application of s 332A of *the 1998 Act* in respect of existing recipients, care needs to be taken regarding the weight that can be given to *Merchant* which predated the 2016 amendments.

93. The decision in *Ali* can be distinguished from the present matter because Mr Ali was not an existing recipient, so Pt 2A of Sch 8 of *the 2016 Regulation* did not apply.

94. The issue in *Sweeny* was similar to the dispute in the present matter, but the worker was seeking an assessment as to whether the degree of permanent impairment was fully ascertainable pursuant to s 319 (g) of *the 1998 Act*. In the present matter, the applicant had three such assessments before the current application.

95. The Deputy President observed that cl 28D (2) of Sch 8 of *the 2016 Regulation* provided that s 322A of *the 1998 Act* did not prevent a further assessment for the purposes of Pt 3 of *the 1987 Act*, namely weekly payments, medical and related expenses, and lump sum compensation, and there was a distinction between an assessment pursuant to cl 11 and the further assessment in accordance with Pt 2A of Sch 8 of *the 2016 Regulation*.

96. The Deputy President concluded that the preferable construction of cl 28 (D) (3) of Sch 8 of *the 2016 Regulation* was that an existing recipient, who has been previously assessed, is entitled to one further assessment pursuant to Pt 2A of Sch 8 of *the 2016 Regulation* for the purpose of determining his or her entitlement to benefits.

97. Of course, the facts in the present matter differ from those in *Sweeny*. In the present matter, the applicant was assessed for the purpose of lump sum compensation in 2011 and 2016. The assessment in 2016 was permitted by reason of cl 11 (4) (c) of Pt 2A of *the 2016 Regulation* which excluded the operation of s 332A of *the 1998 Act* in respect of a claim for "*further lump sum compensation*". The clause does not refer to the words "*further assessment*". Therefore, the applicant satisfies cl 28D (1) of Pt 2A of Sch 8 of *the 2016 Regulation*. The clause applies to a worker whose degree of permanent impairment "*is or has been assessed*". There is no restriction as to the number of times a worker has been assessed.

98. According to cl 28D (2) of Pt 2A of Sch 8 of *the 2016 Regulation*, s 322A of *the 1998 Act* does not prevent existing recipients from seeking a "*further assessment*" of permanent impairment for the purposes of Pt 3 of *the 1987 Act*. This part of the 1987 Act concerns weekly compensation, medical expenses, and lump sum compensation, so it includes s 39.

99. The applicant's claim relates to an assessment that will determine his entitlement to weekly compensation. The present application does not concern a claim for further lump sum compensation in terms of cl 11 of Sch 8 of *the 2016 Regulation*.

100. The referral for the in 2016 was permitted by reason of cl 11 (4) (c) of Sch 8 of *the 2016 Regulation*. The referrals in 2018, 2019 and 2020 were on the basis of determining whether the degree of permanent impairment was fully ascertainable. They did not concern an assessment of permanent impairment for the purposes of s 319 (c) of *the 1998 Act* or Pt 3 of *the 1987 Act*.

101. The AMS was not asked to assess the degree of permanent impairment. He was asked to assess whether the applicant's degree of permanent impairment was fully ascertainable.

102. In 2018 and 2019, the AMS found that the degree of permanent impairment was not fully ascertainable. As a consequence of cl 28C of Pt 2A of Sch 8 of *the 2016 Regulation*, s 39 of *the 1987 Act* did not apply and the applicant continued to receive weekly compensation after the 260-week limit had elapsed. This outcome was beneficial to the applicant.

103. In the 2020 MAC, the AMS found that the degree of permanent impairment was fully ascertainable and given that the respondent had a report that assessed the applicant as having 20% whole person impairment, it ceased payments in accordance with s 39 of *the 1987 Act*.

104. The restrictions in s 332A of *the 1998* and cl 11 of Sch 8 of *the 2016 Regulation* were introduced to restrict the number of claims for lump sum compensation that an injured worker might make, rather than prevent access to weekly compensation and medical expenses if certain requirements were met.

105. Part 2A of Sch 8 of *the 2016 Regulation* must be read as a whole and not in a piecemeal fashion. This provision was intended to give some protection to existing recipients following *the 2012 amendments*. It provides them with an entitlement to a further assessment for the purpose of lump sum compensation and also in relation to a medical dispute relating to their entitlement to weekly compensation.

106. Clause 28C (a) provides that "*an assessment is pending and has not been made because an AMS has declined to make the assessment*" as maximum medical improvement has not been reached and the degree of permanent impairment is not fully ascertainable. In other words, there has been no "*assessment of the degree of permanent impairment*" that is contemplated in cl 28D (1) and cl 28D (2).

107. Clause 28D (2) of Pt 2A of Sch 8 of *the 2016 Regulation* restricts the operation of s 332A of *the 1998 Act* and permits one further assessment of the "*degree of permanent impairment*" for a worker who was an existing recipient.

108. According to cl 28D (3) of Pt 2A of Sch 8 of *the 2016 Regulation*, this is restricted to "*only one further assessment of the degree of permanent impairment*" in order to determine the worker's entitlement to ongoing benefits after the 260-week period has elapsed.

108. I agree with the Deputy President in *Sweeny* that Pt 2A of Sch 8 of *the 2016 Regulation* should be interpreted as a beneficial provision. I consider that it would not have been Parliament's intention to deprive an injured worker, who might well be a seriously injured individual, from access to weekly compensation, merely because the degree of permanent impairment was previously not ascertainable. It is only when a worker has reached maximum medical improvement that an assessment of the degree of permanent impairment can be made, and the assessment is no longer "*pending*".

110. Given the large discrepancy in the assessments of Dr Dias and Dr Powell, a referral to an AMS will achieve the object of the legislation and bring some certainty to the parties regarding the applicant's entitlement to weekly payments.

Accordingly, the Senior Arbitrator determined that the worker is entitled to be referred to an AMS to assess the degree of permanent impairment for the purposes of s 39 *WCA* with respect to both lower extremities and scarring.

Employer's application to rescind the COD issued by Arbitrator Wright on 30/10/2020 under ss 350 and 329 (1A) WIMA is declined – Employer's application to reconsider the decision of the MAP dated 5/08/2020 is declined – Held: the employer's additional evidence was unlikely on the balance of probabilities to cause a different outcome in the MAP's decision

Young Ho Bae v Kids OT Pty Ltd [2021] NSWWCC 62 – Senior Arbitrator Bamber – 24/02/2021

On 23/02/2021, ***Senior Arbitrator Bamber*** issued a COD and Statement of Reasons in relation to the worker's claims for compensation, in which she noted that the respondent had filed an application for reconsideration of the MAP's decision.

The Senior Arbitrator noted that the respondent sought reconsideration based on "*significant fresh and additional evidence*". It sought orders that the Registry and/or MAP should rescind the MAP's decision dated 5/08/2020 and either (a) replace the MAP's decision with a finding that the worker had not reached maximum medical improvement, or (b) refer the worker for further medical examination.

The Senior Arbitrator refused that application and her reasons are summarised below.

The Senior Arbitrator found that all of the "*significant fresh and additional evidence*" that the respondent sought to rely upon was before her at the arbitration, although it argued that it was not available at the time of the MAP's decision dated 5/08/2020. The respondent argued that this evidence would have led to a different result had it been available at the time of the MAP's decision. She noted that the respondent's arguments regarding this evidence can be grouped under the headings of "applicant's failing marriage", "maximum medical improvement", "causation" and "PIRS assessment".

In relation to "applicant's failing marriage", the Senior Arbitrator noted that the worker provided the MAP with a history and that the MAP explained its basis for finding that a 1/10 deduction was appropriate under s 323 *WIMA.* The MAP held that the worker's injury was consistently diagnosed as PTSD and that the impairment described by the AMS primarily resulted from its symptoms. She held that the AMS and MAP were aware of the deterioration of the worker's marriage and she was not persuaded that this "*additional evidence*" would have changed the outcome of their decision.

The Senior Arbitrator rejected the respondent's arguments regarding "*causation*". She held that the MAP clearly found that the pre-existing adjustment disorder was "*minor*" and that the work-related PTSD caused a raft of symptoms and that there was no error in the AMS' PIRS ratings.

With respect to "*causation*", the Senior Arbitrator stated that the respondent did not explain how the additional evidence would have caused the MAP to come to a different outcome, but it asserted that it would have resulted in the MAP re-examining the worker and it would have needed to consider whether maximum medical improvement had been reached. However, the AMS considered that the worker's condition had stabilized, and she was not persuaded that this evidence would have resulted in a different outcome. caused a different outcome.

The Senior Arbitrator noted that the respondent did not point to any particular evidence to support its argument that the further evidence would have impacted on the MAP's PIRS assessment for travel and social functioning. She regarded this aspect of the respondent's argument as being "*too broad brush"* and she was not satisfied that the evidence would lead to a different outcome.

The Senior Arbitrator also stated:

> 36. Finally, it is noted that the applicant submits that the respondent has failed to show why, on the basis of fresh evidence of events which post-date the commencement of the proceedings, that MAP should increase the deduction for a condition that predates the injury without advancing any expert or other probative evidence on the point. I accept this submission has force. It is not necessary to deal with the balance of the applicant's submissions because a key matter that I need to be persuaded of in an application for reconsideration is that the additional material would be likely to change the outcome. For the reasons given above I am not so persuaded.

37. The respondent had also sought to have the Certificate of Determination dated 30 October 2020 rescinded pursuant to section 350 of the 1998 Act. I find there is no basis to do so because of my findings that the additional material is unlikely on the balance of probabilities to cause a different outcome to be reached. It is therefore futile to rescind this Certificate of Determination.