CITATION: *Marco De Beer v Boral Resources Limited* [2004] NTMC 021

PARTIES:	MARCO DE BEER
	v
	BORAL RESOURCES LIMITED
TITLE OF COURT:	Work Health Court
JURISDICTION:	Work Health Act
FILE NO(s):	20218530
DELIVERED ON:	8 April 2004
DELIVERED AT:	Darwin
HEARING DATE(s):	15 – 19 December 2003
JUDGMENT OF:	Jenny Blokland SM

CATCHWORDS:

Work Health Claim – Physical and Mental Injury in the Course of Employment – question of incapacity – Return to work programme – whether failure on the part of the worker – s 75B *Work Health Act* - Effect of ruling by *Australian Industrial Relations Commission* - Normal Weekly Earnings – casual worker - superannuation

Chabrel v Ron Pulla Mills [1999] NTSC 113
Harrower and Harrower v Craig (1993)3 NTLR 188
Miller v University of NSW [2003] FAFC 180
Sedco Forex Australia Pty Ltd v Sjoberg (1997) 142 FLR 169
Hastings Deering (Australia) Ltd v Smith [2004] NTSC 2

REPRESENTATION:

Counsel:

Worker:	Mr Alderman
Employer:	Mr Bryant

Solicitors:

Worker:	Withnall Maley
Employer:	Cridlands

Judgment category classification:	B
Judgment ID number:	[2004] NTMC 021
Number of paragraphs:	87

IN THE WORK HEALTH COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 20218530

BETWEEN:

MARCO DE BEER
Worker

AND:

BORAL RESOURCES LIMITED
Employer

REASONS FOR DECISION

(Delivered 8 April 2004)

Ms BLOKLAND SM:

1. This decision concerns the legal consequences that flow from an injury suffered by Marco de Beer, ("the worker") on 4 March 2002 while employed by Boral Resources Limited, ("the employer"). The employer agrees the worker was injured but denies certain sequelae of the injury and denies the worker was incapacitated at all after about 30 June 2002. The worker also alleges a mental injury (reactive depression) arising out of his employment with the employer. The employer denies liability under the *Work Health Act (NT)* or, in any event, considers that any liability it did have under the *Work Health Act (NT)* has ceased due to the alleged failure on the part of the worker to participate reasonably in a *return to work programme*.

Employment and Relevant Personal History of the Worker

2. The worker migrated from Holland to Australia with his original family in 1971. At the time of the injury and at the time of this hearing he had been in a long-term de facto relationship with his partner Ms Bonning. The

worker and Ms Bonning have a daughter. The worker gave lengthy evidence concerning his employment history. I was impressed with his sincerity at the hearing and having gone over my notes of all of the evidence since the hearing, I adhere to my original impression.

3. Mr de Beer gave evidence that as a young child he travelled around with his parents, living in various regional towns in Australia. He attended various schools and the impression I had from his evidence was that schooling and his childhood were disruptive in some respects due to his parents moving often. He told the Court his level of schooling was not good; his grades were a mixture of "D"'s and "B"'s. He reported poor maths grades when cross-examined about this.

4. After leaving school he commenced work as a labourer with his step father including working in shearing sheds. In cross-examination he confirmed that he left school (Peterborough High School) at the start of year nine or at the end of year eight. From about 1983, he lived with his father and came to Darwin with him. His parents separated when he was relatively young. He lived with his father and his brother lived with his mother. His first work in Darwin was cleaning and servicing swimming pools. In 1984 he returned to Tennant Creek where he had lived previously and commenced work for Warrego Mines. His father was a civil engineer for that firm. From 1984 to around 1985 he worked as a *chain man* (surveyor's offsider) and performed a number of diverse duties including carting heavy truck batteries used in the mine and working as a carpenter. He left Tenant Creek around 1985.

5. At or shortly after this time he met Ms Bonning, went to Cairns, picked up a little bit of work and returned to the Northern Territory in about 1986. The worker gave evidence that at the time of the hearing and for some time preceeding it, when he was in receipt of Centrelink benefits, he was separated from Ms Bonning. Initially I thought this may be a credibility issue but the worker seems to have consciously chosen to live apart to

qualify for a benefit. I took his evidence as meaning for they were still together emotionally. The worker worked at Tindall airbase for about seven months and was involved in road construction, grading and level checking. For some period after this he obtained employment in Tasmania as a general rouse-about and offsider for a shearer.

6. During 1992 he obtained a different style of work as a juvenile correctional officer. This involved supervising juveniles for about 18 months at Giles House. He then had another stint doing labouring style work in Peterborough for about six months and then obtained employment in Dubbo for youth care services that involved befriending street kids and helping them obtain work.

7. He returned to Alice Springs in about 1993 - 1994 and worked as a brick batcher. He then worked as a caretaker at Acacia Hills for a Mr Martin Devlin where he would run eight to nine head of cattle and pigs and look after the farm while Mr Devlin was absent. He also undertook ongoing clearing and other physical work including slashing and fixing fences. He held this caretaking position for about 12 months. He obtained a Housing Commission home and his family moved into it – his daughter was born in 1994. He then worked again in different casual jobs – for example a contract job with CSR involving what he described as *very physical work* that involved some work on a truck and manually mixing steel fibre with cement. In 1997 he ran a bush concrete plant. The work was again of a manual nature and lasted four months. At the completion of that work he didn't have a job to come back to and engaged in some demolition work for Frontier Hotel and some casual work with his father.

Work History with Boral Resources

8. Mr de Beer's brother asked him if he wanted to find some work with Boral and he commenced immediately with *Contract Crushing* said to be part of Boral Resources. He commenced duties at Yarrawonga quarry on 28 April 2000. Initially the work included shovelling and heavy steel work, – mainly

lifting metal and steel around, making rock boxes, assisting the boiler-maker, general maintenance of machinery and blending road bases. These duties continued for several months. In cross-examination he agreed he would get *knocked off* every wet season; he was paid the casual wage; he was not offered permanent employment until 2002.

9. Subsequently the worker commenced working with the employer operating a front-end loader. He would work for six days per week and would be put off seasonally. Initially there was a seasonal break in the employment for around three months and then a return to work. He operated a 470 Komatso at Yarrawonga quarry and was also involved in weigh-bridge duties and issuing manual dockets. He was at times placed at Mt Bundy for certain periods assisting on that quarry, also owned by the employer. In cross-examination he agreed there had been a scaling down at the operation at Yarrawonga; at busy times at the weigh bridge it would be *truck after truck*; he said the volume changed by June 2002, it was scaled back. He was asked specifically in cross-examination and answered that he used a seat belt when operating the trucks.

10. The employer provided training to the worker so that he could operate the loader, dump truck and perform certain other duties. The worker's evidence was that he obtained the *Extractive Industries Class Two Ticket* when working at Mt Bundy. He also pointed to his previous experience in a concrete plant as giving him relevant experience in the field. In cross examination he stated he had operated the Loader Trucks and had been at Mt Bundy in December 2000 for a couple of months; he had the role of caretaker and was then put off in the wet; he would sometimes work 11-12 hour days but it was scaled back.

11. The various records before the Court note there is a work place accident involving the worker on 17 December 2001 at Mt Bundy quarry. In evidence the worker placed this incident at late November 2001 but nothing

of significance turns on that. It is not an incident in dispute in these proceedings. I mention the incident as part of the history for completeness. The quarry produce at Mt Bundy was stored in overhead bins and the trucks were placed under the bins to be loaded. A weld of a conduit was snapped and the worker's leg was trapped in the wedge of the steel frame. The worker reported the matter to his foreman and consulted Dr Forest. The worker reported pain and bruising to the court. He states he returned to work shortly after, either the next day or the day following: *(see exhibits W1 and W2).* There is no dispute on the worker's narrative of this incident. In cross-examination he stated he was usually on the dump truck in Mt Bundy; that although the bruising had resolved from his injury it still *gives him grief* but it does not prevent him working.

The first injury directly relevant to these proceedings

12. On 4 March 2002 the worker was attempting to move a wear plate while he was carrying out maintenance on the wear plates that go over the bucket. The value of the wear plates is that they take the wear and tear instead of the bucket. A locking pin keeps the wear plate in place. The worker's evidence is that on this occasion he couldn't readily remove it without cutting the clip out. He told the court he cut the wear plate ¾ of the way through and hit the top of the wear plate. A splinter of steel lodged into his lower right leg. His immediate reaction, he told the court was that of shock. He told the court the steel went through *three layers*. He pulled his sock away and his leg was weeping clear fluid. He went to the weigh-bridge and told his brother what had happened. His brother assisted to get him to Dr Naidu. The worker told the court he was unable to get down the stairs: (*see also Exhibit W 10, Claim form).* In cross-examination he says he stopped working after the injury with 20 minutes notice; he agreed he considers himself badly treated by the company; he says he thought they provided an unsafe working environment and that he had taken some issues up with the

safety officer – Des Burchett, but felt he should not make waves or complaints.

Initial Medical Treatment

13. The worker saw Dr Naidu at 10.15 am on 4 March 2002 . Dr Naidu gave the worker a certificate for restricted duties. The worker told the court he requested an X-ray but that did not occur on this occasion that he saw Dr Naidu. The worker returned to work shortly after. He worked for nearly two weeks. He reported to the court that he was in pain and the spot where the splinter entered his leg was weeping. When he sought further alternative medical advice an X-ray was done.

14. The worker was told there was something in his leg; he was referred to Darwin Hospital and was told there was a six to eight week waiting list. He returned to work and told the court he felt very sore. He says he felt the splinter was cutting into him. He saw his family doctor, Dr Chin and the splinter was surgically removed out of his leg on 22 March 2004. *Exhibit W4* relating to the surgery notes as follows: *There is an oval shaped opaque foreign body consistent with a fragment of metal 7mm in length at the junction of mid and distal thirds of the calf on the posteromedial aspect and I presume this is in relation to the skin wound.* On 28 March 2002 he was given a certificate for total unfitness for work until 2 April 2004: *(Exhibit W5)*. He told the Court he was prescribed anti-inflammatories.

Manifestation of Symptoms after the Initial Treatment

15. The worker returned to work on or about 2 April 2002. He was certified fit for work from 7 April 2002: *(Exhibit W6).* He gave evidence that he then worked primarily in the weigh bridge taking the weights for customers. He told the court he was limping; he had pain in his leg – a stabbing pain; burning sensations; pins and needles; that underneath the scar he felt like rubbing it or put ice on it; that he felt numb underneath the foot; that the

sensations in his foot changed; that the sensation was mostly up towards the right of his foot and in the instep; he could feel an ache in the ankle joint; that these sensations would last for up to 20 minutes; that he had burning underneath the scar and inside the leg; that the sensation was stabbing and burning and would then go numb for about 40 minutes in the area under the scar; that his foot was asleep a lot of the time; that it would burn on his first step out of bed; that if he got back into the front end loader it would burn and then he would get a stabbing feeling and he would then go back onto weight bridge. At times he would put his leg up; that in doing general work, anything he put on his foot would cause some problem. He said he tried hard to work at the Yarrawonga plant but it didn't get better. He told the court he could not cope.

16. On 30 April 2002, the worker received a medical certificate for restricted duties until 28 May 2002 due to *pursuant numbness and swelling below the wound right lower leg. Nerve damage causing.*. The restriction was that he was to *avoid driving: (Exhibit W7).* He was certified again for restricted duties on 28 April 2002 until 25 June 2002, the restrictions stated were *maximum 5 hours per day work on loader driver (Exhibit W8).* During these periods the worker at times still worked on the front-end loader and worked more than the five hours stipulated.

17. On 3 June 2002 the worker was made permanent. He was no longer on the casual rate and his hourly rate reduced from $15.78 per hour to $13.15 per hour.

18. The worker took up duties of a different type with the employer, working on the dredge at the sand plant. His evidence was this included times when he was on restricted duties. The worker told the court he was placed there to be a dredge operator. He says he was given only two hours training to teach him how to use the dredge. To operate various functions including suction he was to use levers – he did not need to use any foot controls. When

operating, the dredge would shake or vibrate; he would spend time cleaning out mess on the dredge. There were conveyer belts all at different angles, some were steep, some not so steep. To perform some of the duties required him to squat on a conveyor belt that he said caused him terrible pain. He perceived various deficiencies in the operation of the dredge. There was difficulty fitting the cable along the cable drums. He had to obtain assistance when operating the dredge. He experienced great difficulty performing his duties stating that he wanted to put his leg up. For example, he said he had to squat to use the motor; that even to get onto the dredge was difficult; that this action alone would make his leg ache and he also experienced pain carrying a 25 litre drum.

19. He said the drums were full of hydrolich oil and engine oil; he would carry them to the tender and was in quite a lot of pain and discomfort when trying to balance himself on the surface. He said that taking the drums into the engine room and pouring the oil out was difficult because the terrain was slippery and he would have to straddle back and forth at different levels of the floors. He would either be sitting or standing but the vibration of the dredge would aggravate his leg discomfort. He said he would have to crank start the generator on the back of the dredge to get it going. He would also have to carry a five horse power motor. He said there were breakdowns every-day that meant more difficult manoeuvres for him. Sometimes he would work nine hours a day on the dredge. He said that as well as the pain he also experienced swelling.

20. He said that when it got too difficult he spoke to Suzan Renfree (a representative of the employer engaged to assist with return to work)**;** he said he knew it wasn't right with the pain and he told her he could not do the job and would have to quit. He told the court that she said to *please hang in there.* On 19 June 2002 he consulted Dr Moore as he felt he could not cope and could not work. Dr Moore certified him totally unfit for work from 19

June 2002 until 17 July 2002 due to *persistent neuropathic pain, right lower leg: (Exhibit W9).*

The nature and extent of the injury sustained on March 2002

21. The employer accepts the worker suffered the injury in the course of employment, only in as far as it accepts the worker suffered an injury (the "Splinter Injury") when a splinter of steel lodged in his lower right leg (see *The Further Amended Defence of the Employer*). The employer denies the splinter caused damage to the posterior tibial nerve and the distal saphenous nerve of the right leg: (*para 7 Second Further Amended Particulars of the Claim*). Save for the presence of the scar the employer denies the alleged injury sequelae being numbness and tingling; chronic neuralgic pain, allodynia, autonomic dysfunction and poor response to analgesia, nerve entrapment or neuroma formation in the scar left after the removal of the metal; swelling to the leg and pain radiating from the calf to the ankle: (*para 11 Second Further Amended Particulars of the Claim*). In any event, any incapacity beyond 30 June 2002 is denied.

22. I have already noted the early attendances on medical practitioners by the worker. After removal of the splinter on or about 20 March 2002, Dr Moore's records note the worker reported (on April 30 2002), *shock like sensations down to ankle since, aching precipitated by hyperflexion of ankle eg pressure on accelerator. Assess irritated nerve after surgery, suggest injection under wound, but able to put up with it, likely to persist another 1-2 months, using panadeine forte occasionally. (Exhibit W34).* As noted above, on this occasion the worker was placed on restricted duties. On 27 May 2002 Dr Moore's notes record *less discomfort in leg, but persistent sharp pains in back of lower leg now, after a days work. Swelling below wound after wearing boots. Persistent patch of numbness 10 cm stretche, medial lower leg.* As mentioned earlier, on this occasion the worker was placed on increased but restricted duties to include a maximum five hours

per day on the loader or driving. Dr Moore's notes of June 19 indicate the *leg worsening with any kind of work, swelling after 20 minutes work, pain stabbing across wound, aching in ankle region, rest eases pain. Pin (sic) starts at back of lower leg as soon as walks on it. Neuropathic pain, causing difficultyt with relations at work.* Dr Moore wrote a referral letter to Dr Howard Flavell and prescribed Tegretol. On July 2 2002 Dr Moore noted that the worker was *progressing well, less pain, numb patch improving. To stay off work until sees Dr Chin. Appears to be boot pressure exacerbating problem, consider RTW after 17/7, with runner shoes.* On July 10 2002 Dr Moore notes *light shoes better, but still getting pain around ankle, off work till Dr Flavell on 10.08.* On 17 July 2002 Dr Moore notes *will return to work on weighbridge tomorrow wearing thongs, leg has settled with three weeks rest. Feels he is overall improving.* On Tuesday 27 August 2002 Dr Moore notes *consistent problems with right leg, not at work and feeling better without pressure of rtw.* On 25 November 2002 Dr Moore notes *pain on getting out of bed in both lower legs, feeling stiff and tired. Tegretol twice daily doesn't help pain, advised cessation for 1 week to see if improves lethargy & makes any difference to pain...I encouraged him to try the first two weeks sedentary work without boots as this is likely to be no more physically demanding than now. States he doesn't wish to return to work because of friction there, despite my advice that this would jeopardise his WC claim. ...wc cert given 4 hours office work, no boots.* On 1 February 2003 Dr Moore notes the worker is *working for H & R devpts, driving dump truck . Put boots on for 45 minutes and leg swelled, loosened them, worked two days, difficulty with pain, did 8 days similar before xmas, took while to settle, wonders if there is persistent FB* and on 19 November 2003 she notes *has had two jobs since last visit, driving truck driving, any use of the right leg causes pain after ten minutes, jobs lasted 3 weeks, couldn't stand pain...*

23. Dr Moore's notes do also detail symptoms concerned with the alleged mental injury that will be dealt with later. The history of symptoms reported

to Dr Moore was generally consistent with the pattern of symptoms reported to the court by the worker. In relation to the continuation of symptoms since taking up alternative employment, the worker gave evidence of this. As I understand it, he has always been open about the fact, that he did undertake employment for H & R Developments; that this involved basic dump truck driving, moving fill from one truck to another; that there was a lot of pain on his foot; that he would feel pain, then burning sensations, then numbing sensations. The worker said he felt the steel cap boots caused pain; that he felt like he had gravel in his leg; that he would take the boot completely off a lot of the time or at least undo it; that when going to work it was very painful; that his heel felt that it was bruised; that it felt numb. He said it was swollen every day; that from 3 December he worked 10 days straight and then broke for Christmas; that at that time his work was sporadic; that the pain just got too much so he left. Shortly after this time he was referred to Dr McLaren who put him on anti-convulscents.

24. He worked for Ceccon for one week on the road trains and was then put on the front-end loader; he worked on a project at the wharf driving trucks; the nature of the work caused extreme pain on his leg. The worker also told the court of a similar pattern of onset of symptoms on performing work at home such as gardening; working until the pain becomes too much and then needing to rest.

25. Although I have referred to Dr Moore's notes, and the relevant evidence given by the worker, Dr Moore also gave extensive evidence in these proceedings. She said the surgeon's report indicated that the splinter was difficult to remove and irritated the nerve following surgery. Dr Moore commented that a number of the duties performed while the worker was on restricted duties were not consistent with the restricted duties she had anticipated in the certificate *Ex W7*. For example, use of the front end loader for five hours a day, work in a sand pit involving carrying drums down a slope and squatting and various other manoeuvrers were not

consistent with the duties envisioned by her; neither was using a shovel for 4-5 hours, pulling wire and frames for an hour or two or climbing up conveyer belts and removing metal parts from a frame.

26. In relation to the certificate of 27 May 2002 (*exhibit W8)* she also agreed the type of work undertaken at the dredge was not in accordance with the certificate. In relation to prescribing Tegretol to the worker, she explained it was often effective in treating nerve sensations, even phantom limbs. Dr Moore confirmed that on July 10 she considered the worker totally unfit for work and wanted him off work until 10 August when he would see Dr Flavell; this being due to neuropathic pain. She referred to various occasions of prescribing Tegretol, Panadeine Forte and anti-inflammatory drugs. As is detailed below, Dr Moore's view was that the symptoms of depression impacted on the worker's ability to work and in the later stages of her seeing the worker, she was of the view that both the physical injury and the reported depression impacted equally on the worker's ability to work. She confirmed that as of 25 November the worker still reported pain on getting out of bed; that he was feeling stressed and she encouraged him to try sedentary work. She stated that in her opinion physiotherapy would not be expected to help neuropathic pain.

27. In cross examination Dr Moore agreed she spent 10-15 minutes with the worker at each consultation; she stated that she did not think it uncommon that neuropathic pain did not persist with resting, especially with minor injury to the nerve; she agreed the condition of his right leg prevented heavy work but that did not indicate only sedentary work was suitable; she said she didn't recall the type of work the worker was doing when she issued some of the certificates; she agreed that the worker had supplied the information concerning the problems he had with driving; she agreed given the symptoms it would be unlikely the worker could ride a bike or work in the garden; she qualified this agreeing he could put up with pain for some time.

She was cross-examined at length about her involvement in the return to work program.

28. Dr Gavin Chin, Rehabilitation Specialist, currently Director of Rehabilitation Medicine, Royal Darwin Hospital was called in the worker's case. His report of 5 September 2002 (*exhibit W49)* recounts some of the history and refers to a review of the worker on 5 September 2002. Commencing with the period after returning to work after the operation to remove the splinter, Dr Chin states: *He reported immediate post operatively some numbness below the incision and sharp pains in the anterior ankle. It is worse with wearing footwear which touches the skin below the incision. Operating an accelerator and pushbike riding also increased the pain. He has tried to wear his steel capped boots and return to work, but was unable to continue this after four weeks. It is helped with removing the aggravating shoe, but it may take a week for the pain to settle down. He sleeps reasonably well. His appetite is good, but he does report he is getting depressed. He has been trialed on Tegretol, but only in low doses.*

29. *On examination there was a well healed scar. He had good range of movement. His gait was symmetrical. He was unable to walk on his heels or fully squat. On neurological examination he had normal strength and reflexes. On sensory testing he had dysesthesia and mechanical allodynia below the scar.*

30. *In summary this gentleman has neuropathic pain secondary to a surgical incision. I have therefore suggested he trial Zostrix and a therapeutic dose of Tegretol. He may benefit from some physiotherapy to mobilise and strengthen the ankle.*

31. In his report of 27 September 2002 Dr Chin states: *He continues to report burning pain especially after his physiotherapy. He has intermittent stabbing pain which is self limiting. He has a constant ache around the achilles tendon. He has doubled his dose of Carbamazepine. There are*

significant psychological sequelae following his injury. He has a reduction in his income, he is having disputes with his employer and insurer, his claim has been disputed, he has been depressed and angry. He reports that the Carbamazepine, Panadeine Forte and Zostrix have not helped. There has been some slight improvement with physiotherapy.

32. *I have there fore suggested he discuss with his solicitor the issue of whether the recent events are within the Work Health Act. He may benefit from being referred to the Tamarind Centre as the issue regarding treatment for his depression through his insurer will most likely drag on. I would be keen for his Carbamazepine dose to be pushed up to the therapeutic level. If this does not provide any benefit, then I would be suggesting Gabapentin. From the analgesic point of view he could try Mersyndol or Capadex.*

33. In his lengthier report of 28 October 2002 (directed to Ms Susan Renfrey, Senior Injuries Claim Consultant, NRMA Workers Compensation), Dr Chin advises (half way in paragraph 2), ...*He has since developed burning pain below the incisions and sharp pains in the anterior ankle. It is worse with wearing footwear that touches the skin below the incision. Operating an accelerator and pushbike riding also increased the pain. He has tried to wear his steel capped boots and return to work, but was unable to continue this after four weeks. It is helped with removing the aggravating shoe, but it may take a week for the pain to settle down.*

34. *In summary this gentleman has neuropathic pain secondary to a surgical incision.....In reply to your specific questions.*

    1. Mr De Beer is currently unfit to undertake the work trial that was previously agreed to.

    2. The reason why this gentelman is currently totally incapacitated and is unable to participate in the return to work programme is the fact that medically he has limited tolerance for wearing appropriate

footwear, he is unable to tolerate excessive pressure through his right foot and he has ongoing neuropathic pain in the leg. As well as this there are significant psychological sequelae following his injury as well as ongoing disagreement and mistrust of his employer and insurer.

3. *His current restrictions are that he is unable to tolerate appropriate foot ware and functionally use his right leg in the work setting. From the medical point of view he may be left with chronic neuropathic pain in the right leg and these may limit his ability to return to work. With regards to the other issues that I have mentioned it is certainly possible that these could be resolved and therefore make it more feasible for him to look at returning to some form of work, even with the ongoing restrictions.*

4. Mr De Beer's condition has not deteriorated, but has not significantly improved to allow him to be fit to participate in his duties at work.

35. Dr Chin also stated in evidence that carbamazapine has not helped the neuropathic pain; that panadeine forte may be useful but that he recommends a stronger analgesic such as Zostrix or capsicum.

36. In cross-examination Dr Chin was asked whether as at the time of his consideration of the matter, (September 2002) the worker was totally incapacitated for work or whether there was some work he was capable of doing? Dr Chin said that he was totally incapacitated for work he was trained for; he was not fit for heavy work; in terms of rehabilitation work. Dr Chin said that if the worker was unable to return to previous duties, then it was necessary to get him into other work. He was asked what the ideal course of action was in September 2002. He said that given at the time the worker hadn't gone through all treatment, it was best to trial medications and go through work trials. Dr Chin was asked to assume he would go back

to work doing, in part, manual labour. Dr Chin said there were a number of issues with the employer that he had not explored in depth that were affecting the worker psychologically; Dr Chin said he was concerned enough to refer him to Tamarind Centre; that he gained sufficient information from Mr DeBeer to conclude that he needed advice on the *Work Health Act* and a solicitor and that he needed help for depression. Dr Chin agreed that when dealing with chronic pain, depression was quite often a factor; that generally he did explore those issues with patients and refer patients onto psychiatrists if necessary. He said he would generally look at a case conference involving all parties. Dr Chin agreed that with disabilities there can be a range of consequences; with regard to pain, he acknowledged that people react differently to pain. He said that in this case there was a concern about footwear; that if the worker wore heavy industrial boots that would aggravate problem; that in this case steel capped boots would aggravate not just the wound but *below* the wound there was evidence of neuropathic pain – down to the ankle; that boots would be bad for the worker; that this situation would not prevent Me De Beer from walking but it depends on how low cut the shoe was; that sandals would not be a problem; that this worker was unable to walk on his heels; that muscular or tendon movement could also increase the pain and that this was due to damaged nerve endings. Dr Chin said the nerve had been damaged and agreed it was a superficial nerve; he agreed *mechanical alondynia* was a term used to describe when normal stimulus is applied to skin – lightly touching the skin – and general pressure is noted; that *disathesia* referred to an increase in or uncomfortable sensation when touched. He was asked about bike riding; Dr Chin said if he was riding at a fairly sedate pace there may not be a force or pressure; on the question of finding bike riding difficult, he said riding a bike requires a moving of the ankle; he agreed if manual labouring didn't require excessive stress or movement through the ankle, that it may not be a problem; Dr Chin said he saw the worker in 2002 and would limit opinions to that period of time; there was discussion about when the pain flares up, and the reported

need to rest it for a period of time; he agreed neuropathic pain is constant and chronic although the pain could be dulled through appropriate medication; he was asked about swelling and said that it is not a usual complication of neuropathic pain.

37. Dr Jim Burrow, neurologist was called in the worker's case. In his report of 24 February 2003, *(Exhibit W 48)* under the heading: *The nature and extent of the injury sustained* he states: *in summary he suffered a penetrating injury to the left lower calf. There would have been soft tissue injury at the time; this has healed. The history indicates there was injury to the posterior tibial nerve (medial planter branch) resulting in the numbness and tingling over the instep and big toe. This has recovered. There was also injury to the distal saphenous nerve of the right leg. This has not recovered completely. He has chronic neuralgic pain related to this nerve injury – the characteristic features being persistence (despite wound healing), the gnawing aching quality with radiation, allodynia, possibly local autonomic dysfunction (intermittent swelling) and poor response to analgesia. There is also an element of nerve entrapment or neuroma formation in the scar (Tinel's positivity).*

38. Under the heading *Are the injuries consistent with the history?* Dr Burrows states: *Yes, The penetrating wound to the leg and the surgical procedure thereafter resulted in injury to the saphenous nerve and posterior tibia nerve.*

39. Under the heading *What he alleges is his current incapacity* Dr Burrows states: *Mr De Beers indicates that his current incapacity relates to being unable to work in a labouring capacity where he is required to wear protective boots or shoes that provide tactile stimulus to the lower medial calf. It seems excessive weight bearing and mobility at the ankle are also aggravants. By nature of his education and literary skills, he is not suited to other forms of employment.* Under the heading *Are the worker's allegations*

of continuing incapacity, if any, related to the injuries? Dr Burrows answers: *Yes, they are completely related.* In answer to the question *Is the worker totally and/or partially incapacitated as a consequence of his injury?* Dr Burrows indicates *Yes, the worker is partially incapacitated.*

40. Under the heading *If the worker is partially incapacitated, what restrictions do you place on his capacity to work, and what is the expected duration of such partial incapacity?* Dr Burrows answers: *I believe he should not perform physical work, especially that which requires protective shoes. In the long term (time undefined) there may be (gradual) improvement.* Under the heading: *What rehabilitative steps from the point of view of your speciality can be taken to restore the worker, as far as practical, to the same physical, economic and social position as he enjoyed prior to his injury?* Dr Burrows answered: *From a neurological point of view, he requires time and exploration of the other medical avenues suggested. I encourage a very gradual increase in the physical use of the leg, and in the same way a graduated exposure to protective foot wear. I am not convinced that this will be effective, but needs to be tried. As pain is more than 'just a sensation' and is aggravated by other factors such as depression, sense of self-esteem, poor sleep and so forth he requires financial and social support, at the least, if a successful outcome is to be achieved.*

41. In evidence in these proceedings Dr Burrow confirmed that Carbamazapine was an anti-convulsant medication but that for some people it works; that its side effects are insomnia and impaired cognition; that physio-therapy was of no effect. In cross-examination he agreed Mr De Beer had been taking Carbamazapine and Tegretol; he agreed the prescription needed monitoring; he agreed there was no history of joint pain; he suggested that physiotherapy to the wound site would be contra-indicated; he agreed that assessment of the severity of the condition was reliant on history; he agreed there could be great variation on the degree of disability resulting from such an injury; he agreed wearing boots or shoes was an aggravant; he agreed he didn't ask the

worker about gardening and other activities; he agreed that with neuralgic pain it was necessary to try out different activities to see if it precluded the worker from work; he agreed he relies on the patient to assess severity; he agreed he was not in a position to say what the worker could or could not do.

42. Dr Khursandi, a consultant Orthopaedic Surgeon was called in the employer's case. Dr Khursandi assessed the worker on 28 June 2002. His report *(Exhibit E 62)* notes that on physical examination *he walked with a normal gait and was able to walk on his heels and toes. He could stand on each foot with no discomfort.* Further he noted *On examination of his right leg there was no oedema or any muscle wasting. There was a 5cm slightly curved transverse surgical scar on the medical aspect of the right calf, 17 cm proximal to the tip of the medial malleolus. In an area 5 cm x 5 cm around the scar there was slightly decreased touch sensation of the skin. The scar is soft and supple. There is no evidence of any inflammation or significant tenderness of the scar. The underlying calf muscle appeared normal in contour and non-tender.* He further noted under *Summary and Assessment*: *He now has a normal looking scar in the area with minimal decrease in cutaneous touch sensation in the vicinity of the scar. There is no evidence of any hypertrophy or abnormal pathological changes in the scar.* Under the heading *Treatment recommendations and whether further surgery should be considered?* Dr Khursandi states *No further treatment is indicated except massage of the scar with a moisturising cream and application of ice . No further surgery is indicated.* Under the heading *What are the current restrictions that should be in place and how long should these remain?* Dr Khursandi states: *The scar on the medial aspect of Mr DE Beer's right leg does not prevent him from returning to his normal duties as a labourer.* Dr Khurandi also noted the following: *Mr De Beer was fit to return to normal duties at the time of my examination. Mr De Beer will not be left with any permanent impairment. The short and long-term prognosis*

for Mr De Beer is very good. His evidence before the court was brief, confirming there was no swelling around the wound and that a certificate issued by him indicated that the scar did not prevent the worker from returning to work as usual.

43. The employer also tendered a medical report from Dr Kutlaca (*(Exhibit E 58).* That report is primarily is directed to the alleged mental injury but Dr Kutlaca does note at page 9 *In organic terms, there appeared to have been a great deal of physical invalidity following what appeared to have been a very minor event on 4/302, suggesting inconsistency.*

44. In my view the great preponderance of evidence concerning the disabling effects of the physical injury favour the worker's case. At first blush it is true that an injury of the type suffered by the worker would not ordinarily be expected to be so disabling, however, the worker does not strike me at all as someone who is out to exaggerate his symptoms and certainly not someone who is malingering. He has a strong employment history and a strong work ethic. He has had many forms of employment but has almost always worked in some capacity. It is true as counsel for the employer has submitted that a degree of animosity towards the employer can be detected in the way parts of the worker's evidence was given, tending to cast the employer in a negative light. I do not however think that this has impacted on the worker's credibility or sincerity. It is true also that there have been some question marks raised over the worker's medical evidence but these are minor matters that are not central, such as whether swelling could be expected to accompany the injury; whether physiotherapy is of any assistance and whether medically one would expect the worker to be able to ride a bike or garden or be involved in other physical work from time to time. In cross-examination the worker explained he tried physiotherapy at first twice a week but it didn't help and later aggravated. The worker raised the post-operative symptoms with Dr Moore soon after returning to work. The evidence of Dr Chin was impressive and supported the case put by the

worker in terms of the sequelae and confirmation of neuropathic pain. The medical evidence presented on behalf of the employer does not address issues of neuropathic pain. Dr Chin and Dr Burrow are in the appropriate field of specialty to assist the court in the relevant assessment. Some further issues were raised with the worker in relation to his cessation of various medications, including Tegratoll and the use of anti-depressants. In cross-examination he gave a reasonable explanation for this including suffering significant side effects.

45. In terms of his capacity to work in physical, labouring or manual work, the worker has some very limited residual capacity for work. He can work for brief periods as a driver or truck operator but due to the onset of pain after, even a short period, there is little utility in that capacity. He is also able to garden for limited periods of time. What I understand from the evidence is that almost any physical work such as labouring would be the same, given the experience at the dredge. As discussed later, this type of limited capacity does not mean he has a capacity for work in the context of a *Work Health Claim*.

46. A pattern emerges on the evidence indicative of work followed by pain necessitating cessation of work. That pattern is evident even in the employment pattern following cessation of employment with this employer. The bare physical capacity is sporadic. The types of physical work that can be engaged in would be limited also because of the intolerance to protective boots.

47. In terms of his physical capacity to perform other duties, there is evidence that the worker has a capacity to perform light but extremely basic clerical duties. There is evidence that he did perform such duties during the return to work programme, however, on the evidence the type of work he can perform is limited to filling out paper dockets due to his limited numeracy and literary skills. On the evidence, he was still from time to time in pain

and would sometimes perform other duties such as running the pug mill depending on whether there were other people present. The worker has some residual capacity to perform purely sedentary work. As has been submitted, that is not the end of the matter as it is one matter to retain some physical capacity and another to be able to exercise a capacity to work. I will explore that issue later.

The Alleged Mental Injury

48. Aside from the splinter injury and its sequelae, the Second Further Amended Statement of Claim alleges as follows (par 14):

During the period from March 2002 until about 18 July 2002 as a result of the injury; the chronic pain suffered as a result of the nerve damage and as a result of the incapacity suffered by the worker, the suffered anxiety and a reactive depression ("the mental injury").

49. The employer denies this allegation and states (*at 14.1 and 14.2):*

The worker has not sustained any mental injury either arising out of his employment with the employer as alleged or at all; if, which is denied, the worker has sustained a mental injury as alleged, the employer says that such injury arose out of reasonable administrative action on behalf of the employer as the provision of rehabilitation services to the worker.

50. The worker's evidence is that on 17 July 2002 he went to work on the weigh-bridge and found the plant manager was *doing my job*. This factor seems to have caused some friction but in any event, on that day he consulted Dr Moore who gave him a certificate for that day for sick leave (Exhibit W17). On 23 July 2002 Dr Moore diagnosed reactive depression and referred the worker to a psychologist, Jan Isherwood Hicks. In her evidence Dr Moore stated that she made the diagnosis of reactive depression given the circumstances relating to the injury including being unable to work and because of the pain. In Dr Moore's opinion she said the worker

would not have developed reactive depression unless he had suffered the initial injury. She thought the combination of the physical and mental injury made him unfit to work *in equal parts*. In his report of 7 March 2003, Dr McLaren (psychiatrist) concluded:

The psychiatric complications consist of some anxiety symptoms and a reactive type of depression which is not yet sufficiently severe to warrant treatment in its own right. In the absence of any other information, I accept that his physical injury was wholly caused at work and that the complications he now experiences flow directly from that injury.

51. Dr McLaren noted that he prefers to avoid antidepressant medication. He also said: *In the event that there is no improvement in his leg and his employment prospects remain poor, then I would expect that his mental state would continue to deteriorate.* In his later report of 5 September 2003 it is noted that the worker is on a full dose of antidepressants. Dr McLaren's report states that: *He continues to suffer the psychiatric complications of his physical injury.*

52. Much of his opinion was confirmed or enlarged upon during evidence. Dr McLaren stated that when he first saw the worker he thought that through suitable training he would be able to get back to work. He confirmed that with reactive depression, on whether it will worsen or get better depends on external events. In his opinion there was a deterioration of symptoms between March and May 2003. He confirmed that he found the worker to be quite intelligent and well motivated, that with suitable training he would get back to work; that since he first saw the worker, he had deteriorated and he was medicated at an increased dose.

53. In cross-examination Dr McLaren stated that this form of depression was a *common enough* complication of physical injury; he agreed that he noted that initially the symptoms were relatively mild; that having used the term *depression*, he meant it; when it was suggested there was no causative

relationship noted in his report he answered that he had noted them but had left them out.

54. Dr McLaren said that he agreed that there was psychological incapacity from time to time but he also agreed it would have been good for the worker to go back to work. He said that in May the worker was too distressed to do anything. He also agreed in cross examination that rehabilitation into the work force is very important; he agreed in cross examination that the worker was a good candidate for rehabilitation, that he was well motivated; that he was feeling some distress about feeling *useless*; he agreed there was some evidence of anger or resentment but that this was not *striking;* he detected that the worker had felt *let down.* Dr McLaren was also cross-examined on whether the serious injury to the workers' father could explain or contribute to the reactive depression. He agreed this event may have tipped the worker over the edge so it is an event, in his opinion that may have contributed to the mental injury. Dr McLaren stated the worker is now fit to do other work provided it is not heavy manual labour. In re-examination he stated that a lot of qualifications attach to his opinion concerning fitness for work.

55. The worker was referred by the employer to psychologist Louise McKenna. Her detailed report based on assessments of 7 and 11 November 2002 indicates the worker has been experiencing clinically significant symptoms of depression for three months. She states that given the severity of the symptoms she referred Mr De Beer to Dr Moore with a recommendation that he be prescribed antidepressant medication. Ms McKenna concluded: *based on the history provided by Mr De Beer, his presentation at interview and results from assessment dates, it is my opinion that Mr De Beer has experienced a number of psychosocial stresses associated with his injury that have resulted in his experiencing a reactive depression. His depression is treatable with medication and counselling. If left untreated Mr De Beers*

depression will severely limit his ability to participate in a pain management programme and will further reduce his coping capacity.

It is my opinion that Mr De Beer is genuinely motivated to return to work and is prepared to undergo retraining should this be required. His literacy and numeracy skills are limited and reduce his confidence in his ability to work in an area other than manual work. In my opinion, Mr Be Beer would benefit from a vocational assessment to identify the range of skills he possesses and areas of employment he may be suited to given his limitations. Mr De Beer impressed me as a genuine person who would endeavour to implement all strategies to achieve his return to full employment and recovery.

56. In evidence Ms McKenna explained depression can by cyclical depending on how it is managed. She said that if left untreated, a person would have reduced coping capacity including being less able to cope with pain.

57. In cross-examination Ms McKenna agreed her opinions were based on carrying out the IPA depression test, the history from Mr De Beer and the notes from his presentation; she was asked why she did not consider anxiety, she stated the most pervasive of anxiety and depression was the depression although she acknowledges the two can run together; she agreed the test administered was a self reporting test; she agreed the score did not indicate a *major depression* but did indicate a clinically significant depression; she gave evidence that she thought Mr De Beer had given up many activities he enjoyed such as gardening, cycling, fishing and other outdoor activities. I note this does not fully accord with the worker's evidence, there is evidence from him that although under some difficulties, including pain, and needing to rest, he does participate, in a more limited way, in gardening and cycling.

58. Both the worker's own evidence and the medical evidence including the evidence of the primary treating doctor (Dr Moore) and even of Dr Chin who at one stage referred the worker to the Tamarind Centre do establish a

mental injury suffered in the course of employment that became manifest on or about 18 July 2002. The worker was intensely cross-examined on matters of history to determine whether the worker's father's accident in May 2003 was the cause of the depression, however, in my view the evidence all points to the worker's initial physical injury and the failure of that injury to resolve as the primary cause of the depression. It may be seen that other factors, such as the father's accident, impacted on the severity of the depression. Indeed, the pain, the inability to perform his usual physical tasks including work would have all impacted on his mental state. Although there was friction at the work place and much confusion concerning arrangements to do with return to work, these were not, in my mind the cause of the depression.

59. In my view it is the first injury and its sequaela that is the primary cause of the mental injury and consequent incapacity. I note on the question of incapacity *s 53 Work Health Act* requires that the injury *materially* contributes to the incapacity. The contribution was at least material, acknowledging that other factors may have also contributed to its severity. I note also that that Dr Burrows, although not directly called on this issue acknowledged the likelihood that when the injured person feels worse because of the pain, they may get depressed, that in turn aggravates the pain. I have concluded there is great merit in Dr Moore's statement to the effect that the physical and mental injury together produce incapacity.

60. I have noted the report of Dr Kutlaca, Exhibit 58, tendered by the employer who states the worker is not incapacitated from employment from either a psychiatric or a physical perspective. The evidence firmly persuades me to a contrary conclusion. The evidence from medical practitioners involved with the worker over a substantial period of time and with significant ongoing engagement (in the case of Dr Moore) is of greater value in the assessment of this issue.

61. I have noted the authorities suggested by counsel for the worker covering the definition of *mental injury.* I note in that regard particularly *Chabrel v Northern Territory of Australia and Ron Pulla Mills* [1999] NTSC 113. In my view the reactive depression goes beyond *mere grief;* it is more in the nature of an injury to mental or physical health. As indicated above, I have come to the conclusion the leg pain and the depression combined have caused incapacity.

The Return to Work Programme

62. By its amended counterclaim, the employer alleges the worker has not been totally or partially incapacitated as a result of the splinter injury or mental injury further, it is alleged that if there is any incapacity, it is partial only and that the worker has been able to earn (a) Greater than or equal to his normal weekly earnings, or (b) An amount to be determined by the Court. (see paragraphs 28, 29, 30, 31 amended counterclaim)

63. I agree with the submission by counsel for the employer that the worker should be excluded from compensation for the periods he worked for H & R Developments and Ceccon Transport and I note it is common ground the worker was able to earn more than he was able to earn from Boral Resources. In terms of the issue of *more profitable employment* however, these periods of employment were brief, they were infected with pain attributable to the splinter injury and were destined for failure. I doubt that in any real sense they can be treated as *more profitable employment* in the sense intended, although naturally any compensation payable for these periods must be reduced by the sums earned.

64. That issue is also relevant to the alleged failure on the part of the worker to undertake workplace based return to work under s 75B *Work Health Act*. For the purpose of comprehension of this decision I will set out s 75B:

75B. Worker to undertake reasonable treatment and training, or assessment

(1) Where compensation is payable under Subdivision B of Division 3 to a worker, the worker shall undertake, at the expense of the worker's employer, reasonable medical, surgical and rehabilitation treatment or participate in rehabilitation training or, as appropriate, in workplace based return to work programs, or as required by his or her employer, present himself or herself at reasonable intervals to

a person for assessment of his or her employment prospects.

(1A) The employer of a worker who participates in a rehabilitation program or workplace based return to work program under subsection (1) must ensure that program is provided by an accredited vocational rehabilitation provider.

(2) Where a worker unreasonably fails to undertake medical, surgical and rehabilitation treatment or to participate in rehabilitation training or a workplace based return to work program which could enable him or her to undertake more profitable employment, he or she shall be deemed to be able to undertake such employment and his or her compensation under Subdivision B of Division 3 may, subject to section 69, be reduced or cancelled accordingly.

(3) Where a worker so required under subsection (1) unreasonably refuses to present himself or herself for assessment of his or her employment prospects, he or she shall be deemed to be able to undertake the most profitable employment that would be reasonably possible for a willing worker with his or her experience and skill and who has sustained a similar injury and

is in similar circumstances, having regard to the matters referred to in section 68, and his or her compensation under Subdivision B of Division 3 may, subject to section 69, be reduced or cancelled accordingly.

65. Counsel for the worker queried whether *s 75B Work Health Act* applied to this case at all given that there was confused evidence about whether *Subdivision B of Division 3* was applicable. Subdivision B refers to *ss 64* and *65 Work Health Act*. As compensation under both heads was in dispute, it was argued that a condition precedent to the operation of the section was not present. There is indeed competing evidence about certain payments including evidence from Mr Spittle (at the relevant time the NT Manager) that for some time the worker was paid through credited sick leave. This was one of the odd features of this case. Although I do so with some hesitation, in my view s 75B does apply. Its application in this case is more in line with the general philosophy focussing on rehabilitation and return to work and broader underlying principles of mitigation of loss.

66. In my view there were real attempts to put in place a return to work programme. Similarly, there were real attempts to comply on the part of the worker. There was significant confusion surrounding the details of the return to work programme that were not the fault of the worker. In my view it is wrong to penalise him.

67. The workers recollections are that after initial treatment he returned to work, worked on the weigh bridge but had his *foot up* (as mentioned in cross-examination). He said he had nothing to do with the finance side, he filled out dockets; said it was physically lighter work but that he could barely work. He agreed he spoke to Mr Spittle and was prepared to accept full time employment. I have already mentioned some of the evidence concerning working at the dredge. It would appear all around that this in retrospect, even if not known at the time, was highly inappropriate as a

return to work programme for this worker. It placed him in a situation where he was feeling significant pain.

68. Mr Anthony Spittle was the NT Manager at most relevant times. He was aware of the worker's injury of March 2002. He said the worker was given alternative duties on the weighbridge at Yarrawonga involving the worker in issuing manual dockets; he said he wanted to ensure the worker could be provided with all opportunities. He then said the worker was moved to dredging operations at Howard Springs and after the failure of that programme, on advice from the rehabilitation advisers he placed the worker on alternative duties at the weigh bridge.

69. Mr Spittle participated in meetings with Dr Moore concerning discussions on the worker wearing boots; Mr Spittle said he suggested a low cut soft shoe and also checked from an occupational health and safety perspective whether thongs could be worn.

70. Mr Spittle recalls the worker phoned him complaining of a headache and that he suggested he obtain medical advice. He said he believes that was about the last day the worker attended work (18 July 2002). He said he wanted to get the worker back to available work at the weighbridge.

71. In cross-examination Mr Spittle said he had seen the medical certificate in relation to an alleged breach of the Return to Work Programme of 5 July 2002. He told the court that he had agreed with the worker there were anomalies in relation to the medical report. Ms Kristie Thompson who gave evidence for the employer is a rehabilitation adviser. She attempted to facilitate a return to work programme Exhibit E13; the evidence indicates however the worker was told by Dr Moore that he did not need to participate until 8 July 2002. He did in fact attend work on 8 July 2002 in compliance with the Return to Work Programme. It is perhaps regrettable that in those circumstances a letter alleging a breach of the programme was sent to the worker.

72. A further programme was put in place for 18 July 2002. As noted previously the worker did attend on that date but left work complaining of headaches. Dr Moore at around this time diagnosed reactive depression certifying him unfit for work to 4 October 2002 *Exhibit W17*.

73. In my view there was a deal of confusion in the way the return to work programme was to operate. There was a significant "mix up" or "mix ups" relating to the issue of medical certificates and medical approval of the return to work programmes. Initially at least there was a deal of good will exhibited by Mr Spittle and Ms Thompson towards the worker. Unbeknown initially to Ms Thompson, the worker was told by Dr Moore he did not have to return to work until 17 July 2002. Unbeknown to the worker Dr Moore had approved a return to work on 4 July 2002. When contacted on why he was not at work, the worker explained he had his child with him – he was not expecting to work that day. In that context, the alleged breach of the return to work was not unreasonable.

74. I have come to the conclusion that given the confusion associated with the various attempts to return the worker to work; the fact of the diagnosis of depression; the inappropriateness of some of the work offered; the tenuous nature of the position of the weigh bridge (according to Ms Thompson it was for restricted duties); the limited ability of the worker to make relevant calculations to the required level and to undertake other duties expected at the weigh bridge, I have concluded the worker has not breached *s 75B, Workers Compensation Act.*

Cessation of Payments and Employment

75. On the 9th September 2002 the employer ceased to pay the worker. At that time there was in existence a certificate certifying the worker to be unfit for work to 4 October 2002. On the 27 August 2002 the claim form for reactive depression was delivered to the employer. As mentioned, on the 9 September 2002 the employer ceased to pay the worker. On 18 September

2002 the insurer wrote to the worker denying liability for the splinter injury. On 24 September 2002 a further medical certificate certifies the worker as totally unfit for work due to neuropathic pain from 30 August to 24 October 2002. A further certificate certifies the worker unfit for work from 24 October to 24 November 2002 due to both neuralgic pain and reactive depression. Further assessments are undertaken throughout this period by Dr Chin, Dr Moore and a psychologist. The worker was certified as fit to return to work with restrictions at the end of November. On the second of December 2002 the worker contacted the rehabilitation providers stating he will not participate in a return to work programme as he was not being paid. There was also confusion again on precisely what was required; it appears he was required to wear shoes which through previous experience aggravated his pain and would lead to needing to leave work to reciprocate. If this return to work can be seen as a legitimate programme under the *Work Health Act,* then in the circumstances it was not unreasonable for the worker not to comply. He had not been paid since September 2002. I must assess the reasonableness of the worker's activities according to the perspective of all parties. Looking at the matter as a whole, his actions were not unreasonable.

76. It is common ground the worker attempted further employment and obtained further employment with H & R Developments commencing 3 December 2003 for 3 weeks. There were other short periods of employment with H & R and Ceccon Transport. The employer states the worker by this action has abandoned his employment. From the perspective of the *Work Health Act*, the proper inquiry is whether the worker acted reasonably. The employer is not liable for any payments during periods the worker has been able to work and be paid. The evidence indicates he could only work with the new employers for short periods and would then need to recuperate. The real question for me in the context of the *Work Health Act* is whether the worker unreasonably failed to participate in the return to work. Given all of the

problems in the return to work programme and the overlay of depression at the material time, I do not think the worker is disentitled given the action he took. In my view it illustrates the point that this worker was well motivated to work despite his injuries. How can he be obliged to work for an employer who hasn't been paying him, whether by way of wages, sick leave or compensation?

77. The Court has been informed the worker unsuccessfully took action under s 170CE *Workplace Relations Act 1996* for relief in respect of unlawful termination of employment. The employer tendered a copy of the order and decision of Senior Deputy President Watson of the Australian Industrial Relations Commission (Exhibit E31). The Commission dealt with the matter, as it must, as a jurisdictional issue as it can only grant relief in cases where the termination is at the initiative of the employer. The Commission found the worker had abandoned his employment rather than there being a termination by the employer. The Commission, with respect, has not delved significantly into the history of the matter, noting *the mater has a considerable and messy history involving work related injury and related insurance matters and issues of return to work.*

78. I do not consider this court is bound by findings of the Commission in this context by virtue of *res judicata* or estoppel. The findings of the Commission are directed to completely different issues than the Work Health Court. It is not for this Court to make a finding on abandonment or dismissal, this Court simply makes findings in this context on the reasonableness or otherwise of the worker's failure to participate. This takes far broader consideration of issues than those involved in determining unlawful termination of employment. I note there are still doubts on whether the Australian Industrial Relations Commission can be regarded as a body capable of making final determinations from which estoppel may arise and if it is to be regarded as such, the issues are narrowly defined: (See generally *Miller v University of NSW* [2003] FCAFC 180). What is not

irrelevant to these proceedings is the fact the employer purported to dismiss the worker on 9 January 2003 (Exhibit E32). This must have raised in the workers' mind the idea that he was dismissed, not withstanding a finding of abandonment of employment by the Commission.

Extent of the Incapacity

79. As noted above, I have come to the conclusion that it is the combination of the neuropathic pain and the depression that has caused the incapacity. I have also come to the conclusion the incapacity is total.. It is highly unlikely the worker can work in any heavy physical work. He can only do so for brief periods. He has a problem wearing safety shoes that appear to aggravate his symptoms. I would have held out some hope for a job such as the weigh bridge but for the depression and (being optimistic that it would resolve), the problem of the worker having little or no relevant office skills. He had difficulty making calculations, he doesn't seem to have had training in computers. Although I view him as an intelligent person, he will still need a supportive environment and training to be able to compete for an appropriate position. At this stage the worker is totally incapacitated. The fact that he is able to occasionally work does not change that state of affairs.

80. In *Harrawer and Harrawer v Craig* (1993) 3 NTLR 188 at 41 Priestley J said:

I understand their observations to mean that in a case such as the present, the magistrate in deciding whether or not the respondent was totally incapacitated, if he decided the worker could no longer work in well recognised areas of labour, must then consider the sort of special work his residual capacity might make it possible for him to do, the availability of that kind of work and in regard to the last matter whether any such work if not available at hand was available elsewhere within such reach as would be regarded as reasonable for him to travel to in accordance with common conceptions of what is customary in the movement of labourer to work.

81. Applying this reasoning when combining the problem of lack of training, low formal education levels and inability to work at any length of time physically, I fail to see how this worker has residual capacity for work.

82. There are a number of procedural issues that have arisen in this case concerning the service of notices by the worker on the employer (see eg para 16 Further Amended Statement of Claim). There has in any event been some rectification or subsequent compliance. I see no prejudice arising from that.

Normal Weekly Earnings

83. I requested representatives for the employer submit their view and certain issues arising related to Normal Weekly Earnings. In particular, I was interested in the issue of whether NWE should be calculated by way of averaging the wages over 12 months or taking account the casual status in a different way. After reviewing the written submissions I am persuaded this is a case where the NWE should be set by reference to the whole year. I have come to the conclusion that given the loading that casual workers were entitled to , it would be wrong to calculate NWE by reference only to the number of weeks worked. I have come to the conclusion the employer's calculations are more in keeping with the Work Health Act generally and specifically with *Sedco Forex Australia Pty Ltd v Sjoberg* (1997) 142 FLR 169.

84. I agree the Normal Weekly Earnings should be, as calculated by the employer, $549.22 save for making the necessary adjustment for inclusion of compensation for loss of superannuation: (*Hasting Deering (Australia) Ltd v Smith* [2004] NTSC 2, Thomas J) and any further mechanical adjustments necessary.

Conclusions

85. I find the Worker was employed as a labourer/plant operator by the employer, Boral Resources at all material times. He was a worker for the purpose of the Work Health Act. On 4 March 2002 he suffered an injury in the course of his employment when a splinter lodged into his right calf causing damage to nerves in the right leg. Damage was caused to the posterior tibial nerve and the saphenous nerve. The injury resulted in certain sequalae namely numbness and tingling; chronic neuralgic pain, allodynia and poor response to analgesia; nerve entrapment or neuroma formation in the scar left after removal; swelling and pain radiating from the calf to the ankle. The splinter injury and its sequalae in combination with a mental injury (reactive depression) manifesting in July 2002 has caused the worker to be totally incapacitated. Both injuries arose out of the worker's employment with the employer and the combination of these injuries have caused the worker to be totally incapacitated, save for those periods when he was sporadically in employment or attending a return to work programme. The incapacity continues. The employer wrongfully ceased making payments to the worker on or about 11 September 2002. The worker did not unreasonably fail to perform his work place based return to work programme. The worker did not fail to mitigate his loss. I reject the matters raised in the counterclaim.

86. Before making final orders, I request the parties confer and in the light of the findings made thus far, submit a draft minute of orders for consideration. Final orders will need to take account of the various periods for which the worker worked. I intend to make formal orders granting the relief sought by the worker. I note there has not yet been submissions on paragraphs (d) and (c) in the Particulars of Claim.

87. I will forward a copy of these reasons to the party's lawyers today and list the matter for mention on Tuesday 20 April 2004 at 9:00 am for one hour to

deal with outstanding matters and to finalise orders. If 20 April does not suit the parties, there is liberty to apply to the Listing Registrar.

Dated this day of 2004.

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STIPENDIARY MAGISTRATE