CITATION: *Barclay v TNT Australia Pty Ltd* [2006} NTMC 094

PARTIES: JAMES BARCLAY

v

TNT AUSTRALIA PTY LTD

TITLE OF COURT: Work Health Court

JURISDICTION: Work Health Act

FILE NO(s): 20517534

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WORK HEALTH – CANCELLATION OF PAYMENTS – APPEAL – WHETHER CURRENT INCAPACITY CONNECTED CAUSALLY TO INJURY – VALIDITY OF NOTICE CANCELLING PAYMENTS – VALIDITY OF COUNTER CLAIM – VALIDITY OF WORK HEALTH RULE – MEDICAL EVIDENCE – ESTOPPEL – DECLARATORY RELIEF

Work Health Act: ss 69, 110A, 3, 71, 104, 103J, 93, 72
Work Health Rules: 4.06, 9.05, 8.02
Local Court Act: s 14(8)
Makita (Australia) Pty Ltd v Sprowles (2001) 52 NSW LR
Ju Ju Nominees Pty Ltd v Carmichael (1999) 146 FLR 425
Disability Services v Regan (1998) 8 NTLR 73
CEG Ansett Australia v Nieuwmans (1999) 9 NTLR 125
Collins Radio Constructions Inc v Day (1997) 140 FLR 347
TAB Pty Ltd v Gail Dickin [2004] NTCA 8
Swanson v Northern Territory Australia [2006] NTSC 88
Lupton & others v Better Care Pty Ltd & others (1996) 13 NSW CCR 246
Port of Melbourne Authority v Anshum Pty Ltd (1981) 36 ARL 3
James Barclay v TNT Australia Pty Ltd NTMC 12 September 2003
Walker Contracting Pty Ltd v Anthony Edwards 16 March 2001 NTSC
Allison McEvoy v Southern Cross Homes (Broken Hill) Inc, Ashford J, 22 June 2001
Crawford and Opeskin, "Australian Courts of Law", (Oxford University)
Covell and Lupton, "Principles of Remedies" (Butterworths Piers), Ch 5

REPRESENTATION:

Counsel:

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Employer:	Mr McManamey

Solicitors:

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Employer:	Cridlands

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

No. 20517534

[2006] NTMC 094

BETWEEN:

JAMES BARCLAY
Worker

AND:

TNT AUSTRALIA PTY LTD
Employer

REASONS FOR DECISION

(Delivered 4 December 2006)

JENNY BLOKLAND CM:

Introduction

1. This is an appeal against the cancellation of benefits by an employer under the *Work Health Act*. Mr James Barclay (the "worker") suffered an injury at work on 24 August 1999 when employed by TNT Australia Pty Ltd (the "employer"). The original injury was to the worker's back but the worker alleges further that consequently he has suffered chronic pain in his left leg and foot and a pain disorder. The worker maintains this consequence is part of the injury within the meaning of the *Work Health Act*. The employer argues that any condition of chronic pain in the worker's left leg and foot is not causally related to the back injury sustained on 24 August 1999. The employer alleges the worker is suffering from "abnormal illness behaviour" unrelated to the back injury of 24 August 1999 and that such an illness is not a condition that arose out of or in the course of employment. The worker pleads that due to his total incapacity for work he was required to cease his employment with the employer on 12 September 1999 and his employment

was terminated from 12 November 2002. The employer confirms its position on this point asserting that the cessation of employment related incapacity was by reason of the original back injury and not the current condition.

2. It is agreed the worker lodged a claim for worker's compensation entitlements on 22 September 1999 and that liability was accepted on behalf of the employer. It is agreed that by letter dated 4 April 2005 the worker was advised by the employers' solicitors that liability for any further benefits under the *Work Health Act* was denied. The Form 5 Notice attached to the letter (Exhibit W1) advised the worker his benefits were to be cancelled within 14 days pursuant to s 69 *Work Health Act* for the following reasons:

> "You are not suffering from any injury within the meaning of "Work Health Act" ("the Act") which results in or materially contributed to your impairment or incapacity, that and on that basis, you have no entitlement to any compensation such as may be prescribed in Part V of the Act".

The "Further Explanation" provided:

> "You originally suffered an injury as defined in s.3 of the Act on August 1999, being a strain injury to the lumbar spine, for which your employer accepted liability and has made payments pursuant to the Act.
>
> You were examined on 12 August 2004 by a panel of three medical practitioners, for the purpose of a re-assessment of a permanent impairment rating, which was provided to NT WorkSafe on 30 August 2004.
>
> The consolidated panel report, dated 30 August 2004, expressed the opinion that you had no degree of permanent impairment for the purposes of the Act, on the basis that your only impairment at the time of examination was a painful left heel, which was not work related.
>
> A copy of the consolidated panel report, dated 30 August 2004, is attached.

> On 22 March 2005, you were examined by Dr Alison Reid, neurologist. Dr Reid has provided an opinion that you have fully recovered from the injury which you suffered in the course of your employment with TNT Express on 24 August 1999, being a strain of the lumbar spine.
>
> Dr Reid has expressed the opinion that you have a painful left heel which is not work related, and that you are unfit for work on account of factors that are not related to any work injury.
>
> A copy of the report of Dr Reid, dated 22 March 2005, is attached.
>
> Your employer is only liable to make payments of compensation as prescribed in Part V of the Act, including weekly compensation, medical and like expenses, and permanent impairment benefits, if you suffer an injury, and that injury results in or materially contributes to your impairment of incapacity.
>
> On the basis of the medical opinions provided, you are not currently suffering any injury which results in or materially contributes to your impairment or incapacity, and for that reason, your employer is no longer liable to make any payments pursuant to the Act".

3. The worker appeals the decision to cancel benefits. The worker alleges non compliance with s69 *Work Health Act*. The employer has filed a counterclaim asserting that as at 12 August 2004 the worker had ceased to suffer incapacity by reason of the work-related injury. A declaration is sought to this effect. Alternatively it is argued the worker ceased to suffer incapacity as a result of the work-related injury as at 22 March 2005; alternatively the relevant incapacity ceased as at 27 July 2005. The employer originally claimed reimbursement of certain of the benefits paid. Further, the employer amended its defence by adding estoppel based on the determination of the panel that determined that the worker was not suffering from any work related impairment as at 30 August 2004. These arguments will be dealt with below.

Evidence

4. Primarily the evidence called in this case was medical evidence. The worker also gave evidence first. It is acknowledged that strictly speaking the

worker giving evidence first was out-of-sequence given the employer bears the onus on a number of issues concerning the justification for cancellation of benefits. It was acknowledged it was the most convenient course for the worker to give evidence first. Although many and varied procedural issues have been argued, it is useful to make some factual determinations at the outset.

The worker - Mr Barclay

5. Mr Barclay's background evidence was he was originally from Scotland; he had a trade certificate as a mechanic and had served an apprenticeship as a mechanic in Scotland. He came to Australia on 4 December 1980 and initially worked for BHP as a fitter in Whyalla for five years. He said he had no injuries at all at that time. He told the court he moved to Victoria and worked as a mechanic in a garage there. He then moved to Victoria and worked for two years as a mechanic; he then bought into a transport business in Victoria and was self employed for ten years. He did not suffer any lower back problems or injuries. He did not make any claims for worker's compensation. In about June of 1995 he moved to Alice Springs and commenced work with the employer as a courier driver and later in the road transport section. Up until 1999 he did not sustain any injuries save for some back strain in 1998 when he said he had two days sick leave, physiotherapy, returned to work on light duties and then normal duties. He did not make any claim for worker's compensation. There were no other instances when he injured himself at work or at home prior to the date of the injury the subject of the original worker's compensation claim in this case: (Exhibit E2).

6. He said the circumstances of the injury of 24 August 1999 were that he was moving freight through the top of a trailer and he needed to climb through an 18 inch gap to remove the freight from the palette and take it into a gap and he had to crawl back out the same way. He said he felt a little twinge in

his back on the left hand bottom side; he said when he crawled down he felt a bit funny in his back. He said he had a sore leg as well, he only worked another ten minutes and it was the end of his shift.

7. He was unable to perform his usual duty of opening the depot the next morning and informed his manager to open the depot; he came to work two hours later. He said his back and leg were very sore; he said he worked the best he could and went home; he had a radox bath and the next day he had the same problem and did not go to work until twelve o'clock. He said he saw out the day until about four o'clock. He spoke to his manager about it and told him he had a sore back. A doctor's appointment was arranged and he saw Dr Maureen Dwyer and told her he was having problems with his back and leg. She referred him to Dr Art Schmidt but Mr Barclay could not see him immediately so he returned to work on light duties. His leg and back became worse and he was directed to stay home.

8. He said there were a number of certificates and he eventually filled out a worker's compensation claim; his sickness benefits were converted to worker's compensation payments. During that time his general practitioner was Dr Maureen Dwyer and supervision of his injuries was received from Dr Art Schmidt. He said he told Dr Dwyer about his back and leg; he said Dr Dwyer examined his back and leg and couldn't tell what was wrong with his leg. Dr Art Schmidt was supervising his injuries. He said he told Dr Schmidt about his leg as well; he was then transferred to Dr Pannell; he said he told Dr Pannell about the injury and symptoms in his leg and lower back. He said there was pain down his leg when he put his leg down or when he put his foot flat on the ground. He said the pain was in the base next to the heel, just in front of the heel. He said the pain he described and experienced in his left leg and heel was the same pain he felt at the time he was seeing Dr Pannell and Dr Schmidt. He said the symptoms have not changed. He said he had slight pain running down the left leg but most of the pain was in the base of the heel, base of the foot, front of the heel. He said the pain was

mostly on the outside of his leg, from the hip down to the heel and pain on the right hand side of the inner heel. He said he saw a physiotherapist and the treatment involved massaging and working on his back and exercising in a swimming pool; he said it did not provide any relief; he said he did not use weights but he tried to walk as much as he could; he said he was not lifting anything heavy; he said he went twice weekly to physiotherapy but nothing changed; the physiotherapy was over a period of three months. After physiotherapy ceased he went back to his GP; there was no rehabilitation offered and no treatments aside two injections in the facet joint and later on another six injections; he said it did not help.

9. At the time of hearing he was in a wheelchair and said he had been in a wheelchair for about five and a half years; he said he commenced using a wheelchair a year after the accident; prior to the wheelchair he used crutches; he says he uses the wheelchair when he needs to walk long distances or when his foot gets too sore to walk with a walking stick; he said around the house he is mostly in the wheelchair but he tries to keep himself mobile and walks a little bit on his leg but then is back in the wheelchair. He said his left leg has become much thinner compared to his other leg. He said no rehabilitation or retraining had been suggested and he had not thought about it himself as it was just too sore to put the weight on his foot.

10. The worker agreed he had been in receipt of worker's compensation and that it had ceased upon the service of a Doctor's report. (Those documents became Exhibit W1 in these proceedings). As it became evident in these proceedings, the medical material relied on by the employer was obtained as a result of the impairment assessment process. As indicated above, in general terms, the documents comprise a letter from the employer's solicitor enclosing a notice of a decision to cancel weekly benefits pursuant to s 69 of the *Work Health Act*, effective in 14 days. With those documents also is a report from Dr Allison Reid and two reports from Dr Richard Burns. The solicitor's letter reads:

> "As a result of medical evidence received the employer's ongoing liability to you has been reviewed, and you are hereby notified that liability for any further benefits under the Work Health Act is now denied.
>
> We enclose two copies of a Notice of Decision and Rights of Appeal.
>
> Weekly payments will cease 14 days from the date of your receipt of this letter and medical and other benefits will cease immediately".

11. The worker gave evidence that there has always been a slight leg problem but his back recovered; he said there were no back symptoms for over four years. The worker said that apart from the documents in Exhibit W1 he did not receive any other documents. He gave evidence concerning seeing a number of medical practitioners, both his own and those seen at the request of the employer as well as psychologist Mr Tyrell. Mr Barclay said that as well as the left leg being skinnier than the right leg there was a difference in colour as well.

12. In relation to his alcohol consumption he said that he would drink about three of four stubbies per day; in winter it could be one or two. He said he had been drinking since he was about 28 and smoking since he was 17; he said prior to August 1999 he did not have any problems with his legs. He said there has not been any change in his drinking habits or consistency of drinking or smoking since 1999; he said no part of his treatment has been directed towards his drinking.

13. In cross-examination the worker confirmed that currently he had pain in his left foot, inner heel and the sole just before the heel; that sometimes it was like standing on a knife; he said he does not put any weight on his foot if possible. He agreed that has been the case since August 1999. He said it was not severe pain all the time, it was sometimes severe pain and at other times lower level pain. He agreed the heel pain was a matter of importance and it would be a matter he would want to bring to the attention of doctors. He agreed the accident was nearly seven years prior to his giving evidence.

It was suggested to him that he was wrong in his recollection of seeing Dr Dwyer three days after the injury incident; he said Dr Dwyer was wrong on giving the date of 15 September 1999 if that was the date given. He did not concede that he might be wrong on the date. He agreed he told Dr Dwyer he had gradually worsening lower back pain that had started to radiate down to the left calf; he said he could not remember the exact words that he had used but he had told her he had a sore leg; he said the calf was near the heel; he said that he had referred to his left leg and that he had asked Dr Dwyer what was wrong with his left leg. It was suggested to him that he did not tell Dr Dwyer that he was experiencing pain in his left heel or left foot. He replied "*I probably didn't say me left heel or foot I said my left leg*".

14. The worker's compensation claim form was shown to Mr Barclay (Exhibit E2). His attention was drawn to box number 5 concerning the *part of the body affected* and Mr Barclay agreed he made no mention of his heel or foot. It was suggested that that was because he didn't have a problem with his left heel or foot at the time. He said "*I had a problem with my leg, but I didn't know it was caused by my back, I was more in pain with my back when I filled that form out*". Box 5 indicates "back" and in relation to "type of injury or disease" is written "strain". *The Workers Compensation Medical Certificate* of 15 September 1999 (Exhibit E3) was identified by the worker concerning light duties. Mr Barclay agreed that he would have told Dr Dwyer about his back pain each time he saw her and that he would have told her that he was getting pain in the whole leg. He agreed there had been worsening back pain and that he told Dr Dwyer that in relation to his leg, the pain was radiating down his thigh to his knee; he agreed he did not tell her it was radiating below his knee to his calf or foot. He agreed he had not told her that because at that stage it was not radiating down beyond the knee to the calf or foot. He agreed that on about 18 October 1999 he would have told Dr Dwyer that he was getting an ache into his left thigh. It was suggested to him there was no mention of any problem or pain in the lower

part of his left leg; he said that at the time most of the pain was in the left thigh but there was still pain in the leg. He agreed that later in October 1999 he told Dr Dwyer that the back pain had improved but the pain was now in his left hip and thigh. The worker qualified his answer saying most of the pain was in his left hip and thigh. He said the heel pain got worse later on. He said he meant to correct his evidence concerning his statement that he had had the heel problem ever since the incident. He told the court he meant he had the pain in the leg and he meant that the pain in the heel got worse; he disagreed that the pain in the heel didn't come until some time later saying there was "also a slight pain in the heel". On the issue of not mentioning pain in the heel to the doctors, the worker said "I said pain in the leg, I didn't exactly say pain in the heel, I meant the whole leg". The worker agreed that he had told Dr Dwyer that most of the pain was around his hip and thigh. The worker agreed that when he next saw Dr Dwyer he said there had been a mild improvement in the hip pain and that he had lateral left thigh pain on the outside of his left thigh. He agreed he didn't say anything specifically about the heel.

15. The worker agreed he commenced seeing Dr Pannell on about April 2000; he said he was feeling angry at that stage; he agreed he told Dr Pannell he had suffered a back injury on the left side; he agreed he made mention of some pain radiating to his left heel that was described as "a constant ache". The worker disagreed with the suggestion that he did not tell Dr Pannell that standing on his left leg caused him pain.

16. He agreed that on 1 November 1999 he saw Dr Schmidt and told him he had left side leg and lower back pain; he agreed he told him he had pain starting on the outside of the left calf and radiating into the thigh and into the buttock. He agreed that he told him it was present on getting up out of bed in the morning and aggravated by weight bearing. He agreed that he would have told him that most of the pain started in the calf as that was where he said the pain was as that time. Mr Barclay said that the pain was starting on

the top of the leg and that is what he told Dr Schmidt. He said he explained the pain was from the hip down the leg. It was suggested to him that he made no mention of the heel problem to Dr Schmidt; the worker said when he had been mentioning his leg to doctors, he meant his whole leg but most of the pain was from the hip down and he said that there is still pain in the whole leg right down to the foot. He disagreed with the suggestion that he did not complain of pain occurring when he stood on his left leg. He agreed when he saw the physiotherapist that on examination his foot was not tender at that stage and most of the pain was in his hip. He said there was only slight pain in the heel at that time.

17. Mr Barclay agreed with suggestions put to him that his evidence is that from time to time since the accident standing on his foot has caused him excruciating pain and that includes the early stages after the accident. He was asked about seeing a Dr Lugg at the request of the insurance company in June 2000. He agreed that when he saw Dr Lugg he told him that within a few days of the accident he had some back pain; it started to radiate down the left leg. It was suggested to him that he didn't tell Dr Lugg about getting the pain in the heel. The worker said "I think he could see it by the way I was walking in to see him". He said he can't say whether the pain in his leg is shooting down or shooting up. He said he could only say there is pain in the heel when he puts weight on it. He said he would not agree with pain being described as being from his hip or back down his leg. He said he had never described the pain as up or down; he said he would describe it as pain in the leg. He said he couldn't remember saying to Dr Lugg that the pain started to radiate down the left leg. He said he was getting the pain in his heel at the time that he saw Dr Lugg.

18. The worker agreed he saw Dr Maloy in Adelaide in July 2000; he agreed he told Dr Maloy that he had low back pain on the buttock and left leg pain including "down the leg". It was suggested to him he made no complaint to Dr Maloy about any problem with his left heel or left foot. He said "I told

her I had problems walking, could she have a look at it and tell me what was wrong with it". He said he told her he had a sore leg but that he didn't exactly say left foot. He agreed he didn't tell her he had severe pain in the foot. Mr Barclay said the pain that he has now is the same as it was seven years ago. He reiterated that he was getting the pain in his heel but it wasn't as severe as the top of his leg. He said that in 2001 the pain eased up on the top end of the leg. He said his left leg was swelling and discoloured in 2001. He said it was always slightly swollen and discoloured but it became worse.

19. He agreed he went to see Dr Mander in June 2001. He agreed he told Dr Mander that when he placed his heel on the ground he had agonising pain up the leg. It was suggested to him that that was the first time that he had told any of the doctors the problem when he placed his heel on the ground. Mr Barclay replied "when it was getting worse yes". He agreed that it was not until that time that he complained of swelling in his leg – he said it wasn't serious; he agreed he had not previously mentioned discolouration in his left foot; he said that was when it got worse in 2001. He said at around that time that he had a fluid problem and agreed he has liver disease. He agreed that condition had something to do with his alcohol intake. He agreed that problem started in about 2001. He agreed he started to get fluid retention and a grossly distended stomach. It was suggested that he started to get swelling in both legs. He said he couldn't remember both legs, just his left leg. He agreed he had an admission to Alice Springs hospital on 21 September 2001 related to liver disease. He agreed the admission could have been to do with swelling of both legs and abdominal distension. He agreed he had lost some bulk in his leg. He was unsure whether he had wasting in both legs, he said he thinks his left leg was worse than his right leg. He agreed that the hospital drained fluid from his abdomen. He disagreed that the swelling of his legs increased after that time. He said of later attendances at the hospital in 2001 he told hospital staff there was

increased swelling in both legs but he told the court that the left was more swollen than the right. He said that the skin on the left leg had split open because it was swollen more than the right one and that he had an infection. He said the infection was at the top of his left foot. The worker agreed that when he saw Dr Semple on 7 June he described the pain primarily as a burning pain and occasionally the pain was to the leg as well. He agreed it was about that time that he started to use the wheelchair. He agreed he continued to attend the hospital into 2002 and had more fluid drained and had swelling in his legs. He agreed that the last time he had an attendance in relation to that problem was July 2002; he agreed that since that time he had not had abdominal swelling from liver disease and no longer had swelling in the legs; he disagreed that there was an improvement in the discolouration of his foot at that time. He agreed that when he last attended the hospital for fluid retention in July 2002 that was about the time that his back pain resolved. Mr Barclay said that he would describe his pain as being a pain in the back and down the leg but whether they were connected he said "I don't know".

20. Mr Barclay agreed that he did not tell Dr Pannell that it was a pain in the heel but rather would have said it was a pain in the leg. He said Dr Pannell knew he had a pain in the left heel as he could see it. He said the pain was always there in the left foot when he put weight on it. He agreed it was possible that he told Dr Burns in 2001 that originally the pain was not in his foot. He said that in 2001 when he was seen by the panel there was slight swelling in his foot. He agreed that both of his feet were cold at that time. He said signs of redness were present at the time but not as severe as later on. Mr Barclay said the discolouration in his foot varies according to whether he has put weight on it or not. He said what would have been observed by doctors in 2004 and 2005 was not as bad as the discolouration that was observed in the court at the hearing on 19 June 2006. He said there was always slight discolouration.

Medical Evidence Called on behalf of the Employer

Professor Harvey Whiteford

21. Consultant Psychiatrist Professor Harvey Whiteford gave evidence and two of his reports, 8 November 2005 (Exhibit 5) and 24 May 2006 (Exhibit 6) were tendered. Professor Whiteford told the Court he understood that the possibility of a psychiatric disorder had been raised as a result of the fact that Mr Barclay's reported pain and disability were in excess of what was expected by physical examination: (Exhibit E5 at 7). He also notes that a Dr Steven Potter had raised the issue of *abnormal illness behaviour* and psychologist Mr Mike Tyrell had suggested pain disorder. Professor Whiteford concluded in his report (Exhibit 5) that there was no mental disorder such as depression, anxiety or psychosis that was aggravating the pain and which causes the pain to be in excess of what would normally be expected. Further, Professor Whiteford examined whether there was a mental disorder, the manifestation of which is the pain. He said that would amount to a somatoform disorder as suggested by Dr Potter or pain disorder suggested by Mr Tyrell. Professor Whiteford made the point that the fact that the presentation of pain and disability could not be explained by physical disease did not automatically indicate the presence of a mental disorder. Further he said he could not identify the psychological factors which are causally related to the onset of pain which he stated needed to be identified to diagnose somatoform disorder. He qualified that conclusion stating "*however somatoform disorder is a challenging diagnosis to make on a one cross-sectional examination*".

22. He considered whether there was a factitious disorder where the symptoms are consciously faned in an attempt to assume a sick role. Professor Whiteford said that was unlikely. He expressed the view that malingering would need to be considered in Mr Barclay's case, however he acknowledges that malingering is not a psychiatric diagnosis. He could not identify a work related mental disorder. He agreed with the suggestion that

there was a discrepancy between Mr Barclay's pain and disability and the orthopaedic and neurological findings, however he said he could not conclude the discrepancy was due to a mental disorder. He said the only mental health problem was a pre-existing history of alcohol abuse. He said he could not be completely confident he had excluded somatoform disorder. In his later report (E4) Professor Whiteford explains that for pain disorder, (being one of several types of somatoform disorder), the psychological factors must be judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain. He states that relevant psychological factors would need to precede the pain; he refers to anger and frustration being present when he examined Mr Barclay but he said that although they may serve to aggravate the pain he did not believe those symptoms caused it.

23. In cross examination Professor Whiteford reiterated that the psychiatric explanation of pain disorder is a very difficult condition to diagnose when the pain is the manifestation of psychological problem; he referred to the limitations of having examined Mr Barclay only once and he reiterated that he could not exclude pain disorder completely as a cause for his pain because of the symptoms he presents with. Professor Whiteford referred to the difficulty in ascertaining the unresolved emotional issues in a case such as this one because of the number of years the pain had been going on for and the fact that because of the litigation Mr Barclay had seen many doctors and therefore he thought dissecting out any causal relationship was almost impossible. He agreed with counsel for Mr Barclay that seeing Mr Barclay in the context of therapy or treatment may assist in the diagnosis, however he qualified this because of the difficulty in recall back five or six years. He agreed however that if there was no previous psychiatric history prior to the incident in 1999, he would expect that the incident was significant and caused some chain of events which have lead to Mr Barclay's current disability. Professor Whiteford said that in relation to the temporal

connection necessary between the psychological factors that needed to precede the onset of pain, he could not understand if it was a psychological issue why the pain would not have persisted in the back where it originally happened; the localisation of the pain in his foot made him think it was less likely to be somatoform disorder. Professor Whiteford said that although he is not an orthopaedic surgeon or a neurosurgeon he agreed with the proposition that what was called referred pain might bring the matter back to a physical explanation for the pain rather that a psychiatric explanation. Professor Whiteford made the point again in re-examination that if the origin issue is emotions that are converted into physical symptoms the emotions must come before the pain.

Richard J Burns

24. The employer called Dr Burns, a consultant neurologist. Dr Burn's report (Exhibit E7) indicates his opinion is that there is no evidence of any neurologic disorder. He notes the history indicates that the persistent pain in the back is made worse by weight bearing; he notes there is a possibility of an enlargement of the liver and there is something wrong with the texture of skin on the worker's legs and other dermatological abnormalities. Dr Burns says "there seems to be an inconsistency between the history and what is found on examination. As indicated he has no neurologic deficit and I do not consider his pain is the result of nerve root compression". His final comment (p 5) notes "he does appear to be unwell and there seems to be something very much wrong with his leg. I suspect that this has nothing to do with anything that might have occurred at the time of the accident when he was on top of the truck and experienced the twinge of pain…".

25. Dr Burns said in evidence that he didn't believe Mr Barclay had described severe pain in his heel; he said the pain was worse when he stood up from weight bearing but there was no mention made of heel pain to him at the time. Dr Burns states that he would have mentioned heel pain in his report,

(had it been complained of), as *walking on the heels* is a test that is done to indirectly assess strengths. He said that was a standard test that he administers and if there was pain in the heel at the time he wouldn't have been able to do that. That examination was in 2001. Dr Burns said the thickened skin around the calves that was hard and white in colour was unusual; he said it was in both legs and he assumed it was a circulatory disturbance that may be due to chronic venus congestion. On whether those signs were signs of reflex sympathetic dystrophy, he said the colour white on both legs could be a sign of reflex sympathetic dystrophy however it was in both legs. Dr Burns said in evidence that an injury to the heel would not be expected from the history. Dr Burns said he could not think of any mechanism whereby the heel pain was related to the original injury. He said that included reflex sympathetic dystrophy. He agreed that he examined Mr Barclay as part of a panel in August 2004; he agreed that reflex sympathetic dystrophy was one of the matters that he was specifically looking into but that there were no features at that time. He agreed that the worker had a painful heel at that time and that he suggested plantar fasciitis. He said there was no mechanism by which one would develop plantar fasciitis as a consequence of back injury. Dr Burns said that in assessing impairment he came to the conclusion the left heel was not related to the work injury.

26. Dr Burns confirmed that when he examined the worker in 2001 he noted problems related to the liver including stomach swelling and oedema in the form of asciitis; he agreed that condition could explain the signs seen in the worker's legs as at September 2001.

27. In cross-examination Dr Burns explained that reflex sympathetic dystrophy is a controversial and difficult syndrome. He said type 2 reflex sympathetic dystrophy is a pain syndrome that comes on after damage to the nerve; in this case he said there was no evidence of nerve damage. He said if it was type 1 reflex sympathetic dystrophy being discussed it referred to a pain syndrome brought about as a result of a noxious injury to the periphery; he

gave the example where there might be an injury to the wrist and later pain in the hand develops; he said type 1 reflex sympathetic dystrophy can occur following a stroke. He said he could be more confident of a diagnosis when there has been a local injury; the features are weakness; acute sensory symptoms and sometimes changes in skin temperature and skin colour. Dr Burns disagreed that the worker demonstrated weakness to his lower limb. Dr Burns said he would describe muscle thinness rather than muscle wasting, the latter being specific to nerve injury. He said thinness of the muscle doesn't imply disease of the muscles, it just means they are less bulky; he said he did tests for sensory changes in the worker's legs but couldn't find any.

28. Dr Burns said that in 2001 he was reluctant to rule out reflex sympathetic dystrophy, saying he hadn't found evidence of it himself but he knew a number of other specialists had made the diagnosis. He said there was not a strong degree of confidence. He said by the time he reviewed the worker again for the August 2004 report it no longer had a role to play; he agreed with counsel that he could not express an opinion on the origins of the heel pain. He said it was not likely that the worker was still suffering from the consequence of a degenerative disability brought about by the initial reflex sympathetic dystrophy symptoms. He said there was no local noxious stimulus; he said the heel pain came on some years later; he said he didn't agree with suggesting reflex sympathetic dystrophy as a diagnosis because he couldn't be sure what the heel pain was; he said he didn't believe that it was reflex sympathetic dystrophy. He agreed he was prepared to go along with the diagnosis at the outset and said that if it was there previously it was no longer present. He did not agree with counsel's suggestion that the symptoms could have gone but the degenerative process is ongoing. Dr Burns agreed that a resolved reflex sympathetic dystrophy diagnosis was as far as he could take that diagnosis; he said he raised the possibility of plantar fasciitis, being a common cause of pain in the heel on weight

bearing. He said he still didn't believe that the painful heel from weight bearing was a residual manifestation of a previous reflex sympathetic dystrophy. Dr Burns alluded to the worker's condition as being tied up with a venus congestion related to liver disease.

29. In re-examination Dr Burns agreed that a local noxious injury, such as the rupture and lesion of the worker's left foot noted in his history could cause reflex sympathetic dystrophy; he said any spontaneous bleeding of tissues in the leg or foot might do it; he said the markers of the disease are widespread and diffuse and a very rigorous approach had to be taken before making the diagnosis.

Allison Campbell Reid

30. Dr Reid is a specialist neurologist who examined the worker on 22 March 2005; her report of 8 March 2005 became Exhibit E9. Dr Reid's conclusion, after taking a lengthy history and investigation was that the painful left heel is a medical condition and is not work related. She said "there is currently no evidence of a complex regional pain syndrome type one (reflex sympathetic dystrophy)". She said Mr Barclay is unfit for work on account of medical and social factors but not as a result of the subject work related incident. Throughout her report she described the painful heel as an *incidental medical* problem. She noted that the worker did not have one single objective sign of reflex sympathetic dystrophy. She said she could offer no evidence based causal relationship between the painful heel and the work related injury. She said the work related soft tissue lumbar strain has long since reached maximal medical improvement and has settled and ceased. She said the worker is not fit for work as he appears emaciated as a result of alcohol and nicotine abuse; he also has a painful rheumatological medical problem affecting his left heel. Her view was that his immobilisation meant that it would not be surprising to find alteration in the appearance of his feet purely as a reflection of the immobilisation.

31. Dr Reid explained complex regional pain syndrome as an extremely rare disorder which follows an injury to a periphery; she said the strain of the back could not result in complex regional pain syndrome in the foot. Her evidence was that there was no injury to the foot and there could not be a gap of some two years. Dr Reid said that in the period 2001 -2002 her understanding was the worker was "desperately unwell" and that if he had had any sprain or lesion with infection or some injury to the foot there may have been a complex regional pain syndrome; it was suggested to her that the worker had given evidence that in about December 2001 and throughout 2002 he suffered liver disease causing ascites swelling of the abdomen and legs and suffered a lesion on his left foot; she said she did not believe that would explain the pain he gets in his heel now; she said in her experience the strain to his back in 1999 could not explain the pain he has in his heel currently because it is a localised problem in his heel; the heel is tender to gentle touch; she said he is not describing a problem referred from elsewhere. Dr Reid agreed that it was possible that plantar fasciitis could explain the heel because of localised tenderness on palpitation. She said plantar fasciitis is a degenerative condition related to trauma and that it is also poorly understood; she said that it can occur in the absence of trauma; she said it can occur and the cause can be unknown.

32. In cross-examination Dr Reid was asked whether complex regional pain syndrome was difficult to diagnose; she said it is a rare condition and unfortunately diagnosis had been developed on the basis of subjective reporting of symptoms. She said it is generally agreed that it should only be diagnosed on the basis of hard clear objective, abnormal findings. Dr Reid said the diagnosis is mushrooming because it is often made in the litigation setting on subjective reports. She said the diagnosis should be based on scientific objective evidence; she agreed there was legitimate controversy concerning the application of the diagnosis; she agreed people within the profession are still arguing about it but there was a body of literature stating

the conditions should be diagnosed on the grounds of objective findings. Dr Reid said that at the time of seeing the worker he did not have some of the previous symptoms reported to other practitioners, namely he did not have a swollen leg, no oedema, no hypersensitivity, no abnormalities of colour, temperature and sweating and no changes to the nails. She concluded there were no features of the regional pain syndrome. It was suggested to Dr Reid that Dr Cohen had made a diagnosis of the features of regional pain syndrome in January 2003.

33. Dr Reid said that most patients with reflex sympathetic dystrophy ("RSD") get better when they are immobilised; she said an infinitesimal proportion go on to a chronic condition; she said a chronic RSD is shocking and it was absolute nonsense to suggest the worker had a chronic RSD; she said it is a most horrible condition with profound changes to the nails and tendons and the skin. It was suggested to her that the worker is now presenting with a continuation or residuum of symptoms that are attributable to the RSD. Dr Reid said that concept does not exist in literature and is fanciful to explain the worker's localised pain; she said it is much more reasonable on clinical grounds to make a diagnosis of plantar fasciitis. Dr Reid said she would be happy with the label plantar fasciitis to account for the physical findings that she said manifested two years after the injury at a time when the worker was desperately unwell and may have been prone to fall and injure himself or prone to infection, had gross swelling, had low protein and was "very very very ill".

34. Dr Reid was referred to Alice Springs medical records referring to pain radiating to the left heel in April in the year 2000; she said if he had pain radiating down the left leg from the back to the buttocks and down to the left heel that would be sciatic type pain which she said was an entirely different condition. She said the CAT scan and MRI have never shown any evidence of potential neural compression. Dr Reid said she believed there was no connection with the work related injury of 1999; she said the soft

tissue strain should have long since settled and since then the very complex medical problems and immobilisation account for the current situation. Dr Reid was adamant that the heel pain first appeared in the hospital notes on 7 June 2001 although counsel suggested it was April 2000. On 7 June 2001 Dr Reid said the worker had a new foot pain. She said before that time, there was a consistent history of pain in the left leg. She said the doctors looking after the worker found it so complexing they called it chronic pain syndrome. She said there was no substantial evidence to diagnose sciatica. She said there were no radiological findings to support nerve root compression that could give rise to sciatica. She said it makes no difference to her opinion as to whether the heel pain was discovered ten months later or two years later.

35. Dr Reid said that she attributed the wasting of the worker's legs to his liver condition and on going smoking, drinking and generally immobilisation. On whether the immobilisation was due to two years of inactivity from the date of the accident, she said that he was in a wheelchair because of pain in his left heel. Dr Reid disagreed with the proposition that the two years of immobility contributed to the wasting of the upper leg and calf muscles, saying it is a result of his emaciated condition due to liver disease and that the hospital notes in September 2001 mentioned bilateral atrophy and wasting of the legs; she said he had abdominal extension and symmetrical wasting since then. She said the wasting is the result of his liver condition. She said her view was that the muscle wasting is a result of his medical condition but if people are immobile they do get disuse atrophy. She disagreed the liver had recovered; she said instead of being grossly swollen with necrotic liver cells it is now shrivelled up fibrotic and cirrhotic. Dr Reid said she had described the painful heel as "an incidental medical problem", meaning it was entirely incidental to the work related injury, she said she meant no causal relationship co-existed with it. Dr Reid agreed she could not point to any particular trauma on which to base the plantar

fasciitis but she said the usual presentation is just soft tissue and irritating pain in the heel; she said it is very unusual for patients to describe a single event. She said "it's just a wear and tear condition". Of the diagnosis of plantar fasciitis Dr Reid said "it's a fairly confident diagnosis with a guarded prognosis because few people with plantar fasciitis need to confine themselves to a wheelchair. Most people get some padding for their shoes, take some analgesics and get on with their lives despite the pain". She agreed that minor wear and tear (repetitive micro trauma) could be implicated rather than one specific incident.

Medical Evidence called on behalf of the Worker

Professor Alex Cohen

36. Professor Cohen is a consultant physician and endocrinologist. He was asked for reports initially on behalf of the employer. In evidence (Exhibit W12) are the reports of Professor Cohen of 27 January 2004; 10 May 2004; 20 May 2004; 30 October 2004; 26 April 2005. In his report of 27 January 2004 Professor Cohen noted "I would therefore consider that the leg condition is wholly responsible for his inability to work at the present moment and that the contribution of other factors is negligible". He also noted (page 6) that the worker was totally incapacitated by virtue of severe pain, weakness, muscle wasting and relative immobility. The points raised in his report of 27 January 2004 are essentially in answer to questions concerning capacity for work, relationship with the work injury and potentials for treatment. I received the report of Professor Cohen, in particular the report of 27 January 2004 over objection in relation to the reference in that report of reports of other doctors who have not been called (pages 1 and 2 of that report). The objection was on the basis that most of those medical practitioners were not being called. I consider that the fairer way to deal with that matter is to still receive the report as otherwise it would be impossible for Professor Cohen to provide the basis on which he

has formed his opinion, however I would discount conclusions not based on evidence that is otherwise not before the court. Having now had the opportunity to examine the material, I can't detect any facts of significance the have been relied on that are not before the court. Those reports are utilized as points of reference with which at times Professor Cohen discusses and compares his own view. I will disregard the expression of any opinions of Doctors not called that are in his report. Professor Cohen's report of 27 January 2004 is significant in its detail on reflex sympathetic dystrophy as a variant of complex regional pain syndrome. He concludes that the worker demonstrates most of the features characteristic of the complex regional pain syndrome. He says there seems to be a definite correlation between the emergence of the syndrome and the incident in which he was involved; he says the condition is now in a chronic phase but could be amenable to a concentrated therapeutic program.

37. In evidence in these proceedings Professor Cohen confirmed that at examination in January 2004 the worker suffered from a complex regional pain syndrome. He agreed that complex regional pain syndrome was the name given to a cluster of symptoms and signs. He said the "complex" means that it is made up of multi factoral influences, that the "regional" means that it is located in a specific area and "syndrome" is the useful collection of clinical features. He agreed the causes of complex regional pain syndrome remain the subject of debate, explaining that it was previously known as reflex sympathetic dystrophy, and that was at a time when sweating and colour changes were essential; he said it has become understood to be a wider condition than that. He said he thought the worker had reflex sympathetic dystrophy at the time when he saw him and that now he thinks he had complex regional pain syndrome. In his report of 26 April 2005 Professor Cohen stated "there was nothing at the time of my clinical examination on this occasion to substantiate the presence of reflex sympathetic dystrophy". He agreed that the signs of complex regional pain

syndrome had dissipated as at April 2005 but he added that the symptoms had not. He agreed the worker still presents with his remaining symptom being a localised pain of the left heel. He was asked if he considered it compatible with plantar fasciitis; he said that he did not believe it was plantar fasciitis and was referred to his report of April 2005. In that report he stated: "The clinical findings are compatible with those due to plantar fasciitis although the degree of severity, the symptoms and their persistence despite virtually complete rest are uncharacteristic".

38. Professor Cohen reiterated that complex regional pain syndrome is not the same as reflex sympathetic dystrophy; he said the reflex sympathetic dystrophy has a natural history and burns itself out and the worker is left with a localised nerve pain in the heel. He agreed a common cause of complex regional pain syndrome or reflex sympathetic dystrophy was trauma; he agreed that where there was an injury to one part of the body but the syndrome appears in other body parts, the connection that was required is an interference of the nerve function. He agreed that a compromise of the nerves running from the back down the leg, possibly sciatica would be a common occurrence within six months of the injury; he qualified that by saying that irritation at the site of takeoff with the nerve would be sufficient for the connection. He said that possibly one would look for nerve root compression, sciatica but not necessarily. He agreed that if there was a history indicating a contemporaneous injury to the foot itself then that would be more likely to be the cause of the syndrome than injury elsewhere in the body. He agreed there was a wide range of injuries to the peripheral part of the body that could give rise to complex regional pain syndrome; he agreed it could be a minor injury; he disagreed that it could be as minor as bruising to the foot; he agreed that most people who get back injuries don't then go on to get complex regional pain syndrome in the foot. He agreed that an injury to the foot that was fairly contemporaneous with the onset of

symptoms would be more likely to be the cause of the syndrome than the earlier back injury.

39. Professor Cohen disagreed that the complaints of exquisite pain commenced in the middle of 2001; he said he took the first description of it from Dr Malloy in July 2000, however he agreed she didn't examine any complaint involving pain in the heel or foot. He agreed she did not describe symptoms of reflex sympathetic dystrophy or complex regional pain syndrome. Professor Cohen agreed that if the history were that there was no exquisite pain to the heel until mid 2001, it would be less likely that there is a relationship between the back strain and the complex regional pain syndrome. He agreed if a lesion could be pointed to the foot in August of September of 2001 it was possibly more likely the cause of the complex regional pain syndrome. Professor Cohen agreed that on the findings he made in 2004 and the conclusion he reached the only basis on which he could conclude that the worker did not have an impairment due to the injury of August 1999 was if there was no cause or connection between that injury and as he was seen in 2004. Professor Cohen agreed that if the heel condition was causally related there had to be an impairment. He agreed there needed to be caution exercised in relation to a diagnosis of complex regional pain syndrome or reflex sympathetic dystrophy and that it is often misdiagnosed. In relation to the possibility of liver disease and the manifestation of the signs indicative of it, Professor Cohen said liver disease could contribute but he said the major changes suggestive of RSD were in the left leg; he was asked what his conclusion would be if the signs were bilateral in 2001 and 2002 and he said he would be surprised if the swelling due to liver disease was accompanied by sweating reddening heat and localised pain. In answering questions about the history as he knew it, Professor Cohen referred to a report of Dr Parks which was not in evidence however I allowed him to answer the question as that formed the basis of his understanding of the history and evidence on the same issue is in other

medical material before the Court. Professor Cohen said he believed it was the single left leg that captured Dr Park's attention.

40. In re-examination a record of Dr Pannell was put to Professor Cohen that in April of 2000 there was a complaint of "pain down the left lower back, pain… radiation of pain to left heel, constant ache". Professor Cohen answered that the commencement of the problem at that point pointed to sciatica and treated as such by Dr Malloy and others; he said that the finding or complaint of the left heel would not be surprising. He was asked about this in connection with the original injury and in circumstances where there was a presentation of liver problems in 2001. He said that the pain in the left heel in the early stages predicated the connection with the early injury to explain the RSD; Professor Cohen said he didn't think the liver was relevant to the scenario of the back, buttock, leg and heel pain.

Michael St Claire Tyrell

41. The worker called psychologist Mr Tyrell whose report (Exhibit W13 – 24 August 2005) focuses on the question of whether Mr Barclay sustained any psychological injury arising out of the work accident of 24 August 1999 and if so whether he might be incapacitated for his pre-injury employment by virtue of any psychological condition that he may suffer. Mr Tyrell notes that he had three sessions with Mr Barclay namely 23, 30 June 2005 and 18 August 2005. On the last session Mr Barclay's wife accompanied him at his (Mr Tyrell's) request. A number of psychological tests and instruments were administered as were set out in his report and he reviewed a number of medical reports relevant to the worker. After lengthy discussion of history as he knew it, Mr Tyrell concludes that the psychological disorders are consistent with the following:

> **Axis 1 – Psychological Disorders:**
>
> ***Pain Disorder associated with both Psychological Factors and a General Medical Condition (see Axis III)*** – to account for the wide

ranging degree of focus and impairment that Mr Barclay's pain has induced, and recognising that at least some of this will exacerbate the pain experience further, while accepting the medical consensus that the pain is of medical/neurological origin;

Male hypoactive and erectile sexual disorders at least partly causally related to his pain and related lost social function and ability associated with his medical condition;

Partner Relational Problems; whereby the quality of communication and intimacy in his marital relationship has become profoundly and chronically compromised as a major result of his painful condition;

His pre morbid Alcohol Dependency was exacerbated by the pain and related impairment associated with his medical condition for some months or years and may have played a significant role in the liver crisis which arose and abated since the injury;

His nicotine dependency remains almost doubled reportedly because of the injury and its sequelae – with all the longer term prognostic implications that that holds.

Axis II – Personality Disorders: his pre morbid history as provided is not consistent with such disorder.

Axis III – Associated Medical Conditions; refer to the voluminous medical reports and opinion on this matter.

While there appears to be some dispute between medical specialists over how much of his subsequent painful medical condition derives specifically from the workplace injury of August 1999, there appears to be no real dispute as to his current pain syndrome being of medical/neurological origin.

It is acknowledged that this case has been complicated by his co morbid conditions of liver function impairment and alcohol dependency but both these conditions appear to have been assessed as having moderated and reduced in significance concerning his still enduring pain disorder in recent years.

Axis IV – Psycho Social Factors; Mr Barclay and his wife report some ongoing worry over finances especially since they understood to purchase a house at around the time of the injury.

There is little doubt that the level of functional impairment that Mr Barclay exhibits in the home, and including his ceased sexual

> functioning and disturbed sleep patterns which all reportedly emerged very soon after the injury, had caused ongoing strain between the couple. This has in particular placed his wife under very considerable strain since the injury.
>
> The high degree of social and functional impairment that the injury has led to has in turn led to social isolation in this couple.

42. Mr Tyrell states in relation to the Axis I diagnostic formulation "It is reasonable to consider all these conditions or exacerbations of pre existing conditions as psychological injury which derives in some or all degree from the injury, based on the provided history to hand of the temporal links to the injury". Mr Tyrell's evidence was that through viewing the medical reports and speaking with the worker and his wife he was satisfied there was a trail or link between the original injury and the conditions he has now diagnosed. He confirmed that under Axis I a pain disorder associated with psychological factors indicated a psychological condition; Mr Tyrell agreed that he was not a medical practitioner so he made certain assumptions or assessments based on the reports that he had in relation to some form of general medical condition. He said he relied on pain disorder as the primary disorder and the primary diagnosis. Mr Tyrell said that the pain disorder concerned a complex parade of processes including physical, psychological and social; he agreed that when he spoke about pain disorder he was talking about something different from some other forms of disorders that are created solely by psychological processes. He said his opinion was that there was a physical injury and as a consequence of that the pain disorder had developed.

43. In cross-examination Mr Tyrell agreed that he had relied on the physical symptoms and the history and reports concerning Mr Barclay to connect the current condition with the incident in August 1999; he agreed that any questions concerning medical causation was outside of his area of expertise; he said he was not necessarily reliant on the medical links in relation to pain disorder; he said the experience of pain disorder is quite specific. Mr Tyrell

said that any number of psychological traits could be a reaction to the physical injury for example emotions such as distress or leaving a person with a sense of helpfulness, grief, abandonment or anger. He agreed that frustration and anxiety referable to serious liver condition and multiple hospital attendances may give rise to the psychological factors although he did say that people who drink alcohol in quantities usually rationalise that and also increased alcohol dependency could be linked to the injury; he agreed that the history of alcohol use in his report was not clear; he said he had never seen pain disorder emanate out of a purely alcohol related disability. He said he had seen it arise from a wide number of psychological factors and physical conditions; Mr Tyrell agreed that it was his understanding that the worker had the pain in his foot or heel since close to the time of the accident; he said that he didn't actually rely on the fact of his foot feeling the way that it does now to come to the conclusion of pain disorder; he said he deduced from the reports that the pain evolved following various other patterns that started with his back and his left leg. It was put to him that if the true history was that there was not a problem with the foot until a couple of years after the accident then the basis of his opinion would be diminished; he answered that that is where pain disorder is so complex as there is no requirement that there be a physiological chain; he said that the worker suffered for many years with a pre-occupation of pain in the underside of his foot that he links through to the original event; he said if there had been psychological assessments around 1999 and 2000 there would be a much better view of the fine detail of the events; he said it was unlikely there was another cause of the injury to his foot; he agreed that would be dependent on the opinion of medical experts and the history.

44. I heard Mr Tyrell's evidence subject to objection, essentially on the grounds that his opinions do not amount to expert evidence because the basis of the opinion is not properly proven, especially the evidence given by Mr Tyrell concerning the worker's lack of sexual function, emotional distress and

grievance and reliance on the worker's wife's history who accompanied the worker on attendance to Mr Tyrell. Counsel for the employer reminded me of the authority in *Makita (Australia) Pty Ltd v Sprowles* (2001) 52 NSWLR where His Honour Justice Heydon makes strong and definitive statements concerning the need for strict compliance with the basis rule as informing admissibility rather than weight. From the point of view of strict orthodox compliance it is true that this report does not comply completely with the basis rule requirement. On the other hand, much of the history is in evidence. I agree there was no evidence of sexual dysfunction separately given but that does not appear to be a significant part of the basis of the opinion; the worker gave little evidence of his moods to the degree that Mr Tyrell relied on, but he did give some evidence as to his anger. I agree his evidence on this point was scant. The history relied on by Mr Tyrell from the worker's wife seems to be more in the nature of confirming certain matters that the worker spoken of in his sessions with Mr Tyrell. In a jurisdiction requiring strict and formal proof on all matters I would consider the employer's argument more favourably, however s110A *Work Health Act* provides that the Court *"is not bound by any rules of evidence but may inform itself on any matter in such manner as it sees fit"*. Particularly given that the rules provide for exchange reports such as those by Mr Tyrell, weaknesses arising from the lack of foundational evidence can be pursued to some degree with Mr Tyrell and the worker and various doctors. It is not inherently unfair to admit this report but I consider any lack of factual basis as a matter of weight and I would admit it pursuant to s110A *Work Health Act* as despite the deficiencies, it is of assistance to the Court. Having said that, in my view the weight that can be given to the opinions expressed is significantly diminished because aside from an expression of anger at an earlier time, there is little in the way of any comprehensive evidence from the worker of the types of emotional issues that Mr Tyrell has relied on in forming his opinion.

Onus of Proof

45. Although there was something of a challenge made to the question of onus of proof, in my view the authorities are clear that when hearing an appeal against a decision of an employer to cancel benefits under s69 *Work Health Act,* the onus lies on the employer to justify the cancellation, or, as it is sometimes put, to prove the matters it relies on in the notice cancelling the benefits. As it turns out, this point may be academic as on consideration of the Notice dealt with below, I have found it to be invalid. If I have concluded wrongly on that point, the employer carries the onus of establishing the change of circumstances warranting the cancellation: *Ju Ju Nominees Pty Ltd v Carmichael* (1999) 146 FLR 425; *Disability Services v Regan* (1998) 8 NTLR 73. The notice, not the medical certificate needs to be justified factually, and on this the employer bears the onus: *Henry Walker Contracting Pty Ltd v Anthony Edwards* 16 March 2001 NTSC, Angel J. It has been advanced on behalf of the employer that as the current condition causing incapacity (exquisite pain to the arch next to the left heel) was not the injury the employer accepted liability for in 1999, (being soft tissue injury to the lumbar spine), that the employer bears the onus only in relation to proving the soft tissue injury is no longer the cause of the incapacity. It was argued that the pain in the left heel arch was a new injury and the onus was with the worker. This approach has been rejected on a number of occasions (eg. *Henry Walker Contracting Pty Ltd v Anthony Edwards* (supra)) and other cases cited above. It must also be remembered that the definition of "injury" in s3 *Work Health Act* is wide and is interpreted to include the results or consequences of the injury arising out of employment. Not to interpret "injury" in this way would mean that developments of the injury or effects (possibly unknown at the time of the original injury) causing incapacity would exclude incapacitated workers. It is the incapacity and its relationship to the injury that is the question.

46. In any event, the employer also bears the onus on the counterclaim that for reasons I mention below I have come to the conclusion is validly brought. Leaving aside for now the procedural aspects of this case, the merits are to be determined by reference to the onus resting on the employer, whether ultimately the merits are determined by reference to the original appeal by the worker of by reference to the counter-claim.

47. This is not a case where the worker has sought to plead a wider case than the pleadings. In my view the worker's case as pleaded merely meets the issues specifically raised in the Notice of Decision: (Exhibit W1). The Notice of Decision specifically raises the point that the current condition (painful left heel) is not work related and that such a condition does not contribute to the incapacity. The Statement of Claim, in my view, should be properly characterised as meeting that allegation; in particular, paragraph 2 of the Statement of Claim alleges: "*On 24 August 1999 the worker suffered an injury to his back during the course of his employment and consequently he has suffered from chronic pain in his left foot and pain disorder ("the injuries*")". This being the format of the proceedings, I see no reason to depart from the general rule that the employer bears the onus.

Assessment of the Evidence

48. Essentially these proceedings concern whether the localised pain in the worker's foot is causally connected to the injury in August 1999. To succeed, the employer must prove on the balance of probabilities it was not. In favour of the employer's case, Dr Burns and Dr Reid are clear – they conclude the relevant connection to the original injury is not present. The original back pain does not incapacitate him. It is clear that has resolved and the foot is not part of that injury. There are, however, a range of opinions before the court on this matter. It is clear there is no injury to the foot as at the time of the accident. Dr Reid strongly favours plantar fasciitis as a condition explaining the problem of the heel pain; she says it is a

"fairly confident diagnosis" although she still qualified her diagnosis. Detracting from her conclusion, is the lack of repetitive micro trauma evident from the fact the worker has spent five or more years in a wheelchair. Still she is genuinely firm or confident of that diagnosis. It is true also she did not have ongoing therapeutic care of the worker but saw him only in the context of the impairment panel. Dr Burns also suggests plantar fasciitis. Professor Cohen found clinical findings compatible with plantar fasciitis in April 2005, although he said he did not believe it was plantar fasciitis given the severity and persistence of symptoms. I can't on balance positively find that the worker currently suffers plantar fasciitis – there are too many uncertainties around the diagnosis. That is one matter going against the employer's case, but it doesn't mean the lack of a firm alternative diagnosis defeats the employer's assertion that the current incapacity is not related to the original injury. That is but one factor.

49. It must also be remembered that no party or medical practitioner is suggesting malingering on the part of the worker and I can easily rule that out. There is also the circumstance of the worker being highly restricted and confined to a wheelchair or utilising crutches for many years as well as the fact that before his injury he had no significant injuries or conditions. Despite those surrounding circumstances tending to weigh in the worker's favour, in my view the clear preponderance of the evidence is against the worker's case that the current condition is connected to the original injury. There is no longer any physical connection between the injury to the foot and the original injury. The first time documented when the worker raised heel pain with medical practitioners is April 2000 (Exhibit E10) "radiation of pain to L heel…….constant ache" and "radiation of pain to L leg – heel". The worker's evidence is very unclear on when he first noted pain in the heel. At times he related that the heel pain was an early observation he made to doctors and at times he agreed he had not mentioned his heel or foot, conveying to the court that at earlier times in his presentation when he

mentioned his leg or calf, he also meant to include pain in his foot or heel. I found this explanation unconvincing, accepting that at later times he experienced acute pain in his foot or heel. I just find it hard to believe in a context of describing pain, he would not have included the "foot" or "heel" if that in fact was the end point or starting point of the pain. It is true that radiating pain was reported and noted in April 2000 and there is some evidence supportive of sciatica at around that time, alternatively as Dr Reid noted, "referred pain". The weight of the evidence suggests this is not the pain the worker currently experiences or recently experienced – he describes primarily a localised pain (aggravated by weight bearing). I agree it must be very difficult for the worker to recall symptoms, and his descriptions at various stages throughout the last five to six years, however the records and various histories do not support a description of the heel or foot pain that is consistent with his current experience of pain. The pain is quite different to the radiating pain that was noted previously. It is not the excruciating localised pain on weight bearing. Dr Reid also gave evidence that the CAT scan and MRI have never shown any evidence of potential neural compression. In my view the combination of the history given by the worker to medical practitioners combined with the evidence of Dr Reid strongly rules out a neural connection between the current condition and the original injury. Although there is mention of pain radiating to the left heel in Dr Pannell's notes in April 2000, there is no description by the worker given of his current condition concerning his *heel* until seeing Dr Mander in June 2001. There is an expression of radiating pain to the left buttock and left lateral thigh *and* calf and that it is more severe when putting weight on his left lower limb or sitting to Dr Molloy on 24 August 1999 but that too falls short of the description of the pain given by the worker over the last two years. I don't accept the worker's evidence that he had been effectively making this complaint all along although the heel pain increased over time. The worker's evidence is unreliable concerning the description of the histories given. In my view the evidence of Dr Reid is compelling when one

compares her general opinion about the worker being generally unwell with the hospital records indicating the same.

50. I accept there is a range of acceptable medical opinion concerning the diagnosis of reflex sympathetic dystrophy or complex regional pain syndrome. I accept that Dr Reid may well be, as suggested by counsel for the worker, on the "conservative side" of being prepared to diagnose such a condition however, I found her evidence to be compelling, logical and confident. She rejected very strongly that the worker could be suffering chronic reflex sympathetic dystrophy and she described as noted above that this is a really horrid looking condition far beyond anything observed on the worker. From that discussion it is evident she does not completely reject the existence of such a condition but she confirms how rare it is and how the worker does not fit the criteria for diagnosis.

51. Dr Burns's evidence also confirms that there is no evidence of damage to the nerve. His evidence also supports the conclusion that the worker's various descriptions of his history are not reliable as Dr Burns clearly states that had there been mention of heel pain he would have administered a standard test. He acknowledges that at an earlier time he was prepared to entertain reflex sympathetic dystrophy in relation to the worker and in my view this indicates he does not have a closed mind to such a diagnosis. Bearing in mind he is somewhat sympathetic to the idea of reflex sympathetic dystrophy, he too confirmed that on his review of the worker in August 2004 any reflex sympathetic dystrophy that may have been operative no longer had a role to play. Both he and Dr Reid reject the notion that the symptoms could have gone but the process is ongoing or the condition is no longer present but causes the symptoms. He did not agree there could be any residual manifestation of the previous reflex sympathetic dystrophy. In my view Dr Burn's evidence is significant given his openness to a previous diagnosis. He agreed he was not confident about this earlier view but he was very confident in ruling it out in his last review. Dr Burns also offered

the view that a local noxious injury such as a rupture or lesion of the foot in the history of the worker could cause reflex sympathetic dystrophy. I note that there is some evidence of this in the hospital records in September 2001.

52. Professor Cohen confirmed that in January 2004 his diagnosis was that the worker suffered complex regional pain syndrome. By April 2005 he could not substantiate its presence. In his opinion, despite the dissipation of complex regional pain syndrome, the symptoms are still present. Interestingly he was of the view that a contemporaneous injury to the foot would be more likely to be the cause of the syndrome than an injury elsewhere in the body. This resonates with parts of the opinion of Dr Burns and Dr Reid. In my view Professor Cohen has not explained the mechanism by which the symptoms continue in a way that is referable to the supposed complex regional pain syndrome when that syndrome has dissipated. Further, it is not in turn explained how that is referable to the injury or the progression of the injury. I strongly prefer the evidence of Dr Reid and Dr Burns over Professor Cohen's evidence.

53. In relation to the possibility of a mental disorder or psychiatric or psychological disorder that is referable to the injury, I note Professor Whiteford indicated that for pain disorder, the psychological factors need to precede the pain. He explained why anger and frustration being present when he examined Mr Barclay might serve to aggravate the pain but would not be the cause of it. He agreed there were limitations to his opinion given he had examined Mr Barclay only once and he said he could not exclude pain disorder completely. It must be remembered that the worker's evidence was that prior to the injury he had no significant health issues. Certainly there was no clear evidence of any emotional or psychological issues prior to the injury. Professor Whiteford was open to a suggestion that given there was no previous psychiatric history, the incident of 1999 could be expected to be relevant in the chain of events leading to the worker's current

disability, however he was of the view that the pain would have persisted in the back where it originally happened. The localisation of the pain made him come to the conclusion that this was not a somatoform disorder. In my view Professor Whiteford made appropriate and genuine concessions. Following his thought process, the link between the current condition and a mental injury is on balance unlikely.

54. Mr Tyrell had three sessions with Mr Barclay as opposed to most of the other medical practitioners and in particular Professor Whiteford who only had one session with the worker. Despite this, and despite the fact that Mr Tyrell has obviously taken a therapeutic interest in the worker which is to his credit, overall the opinion is not strong concerning a psychological injury manifesting in the worker's symptoms. Although Mr Tyrell quite rightly relied on psychological traits that he thought led to the development of pain disorder, there is some but not a great deal of evidence supportive of the types of emotions Mr Tyrell relied on. I have already referred to the fact that the weight of Mr Tyrell's opinion needs to be discounted to some degree due to there being little in the way of satisfactory evidence on those points. In terms of any cause to the injury to his foot, Mr Tyrell said he was dependant on the opinion of medical professionals and the history concerning it. Some of the history Mr Tyrell was given appears to be unreliable, in particular he appears to have relied on a history concerning an increase in the alcohol consumption after the accident, however that is not the evidence of the worker. Counsel for the employer criticised Mr Tyrell's view in as much as it was based on tests that were taken home and filled out. I wouldn't discount the opinion for that reason as Mr Tyrell is I think entitled to administer tests in the way that his profession accepts, or in accordance with his usual practice, however I do think his opinion in all the circumstances does not carry the weight of the other medical opinion before the Court including Professor Whiteford. I do not think the mechanism by

which Mr Tyrell says the pain disorder is connected with the original injury has been clearly explained.

55. I bear in mind that although I have mentioned that the worker is unreliable in terms of his reporting of the histories that he has given, I in no way think he is not desirous of telling the truth, nor do I find the worker is malingering. In my view however the employer has strongly demonstrated on the balance of probabilities that the incapacity does not arise from the original injury, nor is there a causal link between the two. It is true that the heel pain is not comprehensively referable to a specific diagnosis, but in my view the probabilities lie in favour of the fact that the worker is generally unwell and the probabilities lie in favour in my view of the description given by Dr Burns to the effect that the worker's condition is tied up with a venous congestion related to liver disease and that a local noxious injury such as the rupture or lesion in the worker's history caused the pain. There are a number of explanations that have been put forward on what has caused the worker's pain in his left heel. I am unable to make a specific finding on that matter given the state of the worker's health however I am firmly of the view that it is not related to the injury arising out of employment, accepting the wide construction of "injury" within the meaning of the *Work Health Act*.

56. Specifically, I find the worker suffered an injury at work on 24 August 1999 during the course of employment; the injury was a soft tissue injury to his back; the employer accepted liability; the worker ceased employment due to incapacity for work with the employer; the worker's employment was terminated from 12 November 2002. On 15 September 1999 the worker complained of low back pain radiating down the thigh to the knee; the worker complained of radiation of pain to his left heel in April 2000 to Dr Panell; I find that the pain complained of at that time was radiated pain and that pain resolved. The worker also complained of radiating pain to the left buttock and left lateral thigh and calf including more severe pain when

putting weight on the lower limb in August 1999. I find that the radiating pain resolved. I find that the worker currently suffers severe exquisite pain in his left heel and that the first time the worker has made complaint of that pain was on or about June 2001. I find that in September 2001 the worker was admitted to Alice Springs Hospital with symptoms including abdominal distension and swelling (bilateral symmetrical atrophy of the legs), oedema and cellulitis; he also suffered from a lesion to the foot. I find the worker was unwell, suffered liver disease and associated symptoms and suffered pain in his heel that can no longer be related in any causal sense to the original injury; I find the original injury and/or its sequela and consequences have resolved and were firmly resolved by 12 August 2004 being the time that he was examined by medical practitioners who made relevant findings.

The Validity of the section 69 Notice

57. As indicated above the worker argues non-compliance on the part of the employer with the s69 *Work Health Act*. As a result of my findings the case will not be determined on that point but for completeness, s69 *Work Health Act* provides:

> **69. Cancellation or reduction of compensation**
>
> (1) Subject to this Subdivision, an amount of compensation under this Subdivision shall not be cancelled or reduced unless the worker to whom it is payable has been given –
>
> (a) 14 days notice of the intention to cancel or reduce the compensation and, where the compensation is to be reduced, the amount to which it is to be reduced; and
>
> (b) a statement in the approved form –
>
> (i) setting out the reasons for the proposed cancellation or reduction;
>
> (ii) to the effect that, if the worker wishes to dispute the decision to cancel or reduce compensation, the worker

may, within 90 days after receiving the statement, apply to the Authority to have the dispute referred to mediation;

(iii) to the effect that, if mediation is unsuccessful in resolving the dispute, the worker may appeal to the Court against the decision to cancel or reduce compensation;

(iv) to the effect that, if the worker wishes to appeal, the worker must lodge the appeal with the Court within 28 days after receiving a certificate issued by the mediator under section 103J(2);

(v) to the effect that the worker may only appeal against the decision if an attempt has been made to resolve the dispute by mediation and that attempt has been unsuccessful; and

(vi) to the effect that, despite subparagraphs (iv) and (v), the claimant may commence a proceeding for an interim determination under section 107 at any time after the claimant has applied to the Authority to have the dispute referred to mediation.

(2) Subsection (1) does not apply where –

(a) the person receiving the compensation returns to work or dies;

(aa) the person receiving the compensation fails to provide to his or her employer a certificate under section 91A within 14 days after being requested to do so in writing by his or her employer;

(b) the medical certificate referred to in section 82 specifies that the person receiving the compensation is fit for work on a particular date, being not longer than 4 weeks after the date of the injury in respect of which the claim was made, and the person fails to return to work on that date or to provide his or her employer on or before that date with another medical certificate as to his or her incapacity for work;

(c) the payments of compensation were obtained by fraud of the person receiving them or by other unlawful means; or

(d) the Court orders the cancellation or reduction of the compensation.

(3) Where compensation is to be cancelled for the reason that the worker to whom it is paid has ceased to be incapacitated for work, the statement under subsection (1) shall be accompanied by the medical certificate of the

medical practitioner certifying that the person has ceased to be incapacitated for work.

(4) For the purposes of subsection (1)(b), the reasons set out in the statement referred to in that subsection shall provide sufficient detail to enable the worker to whom the statement is given to understand fully why the amount of compensation is being cancelled or reduced.

58. It is clear that the medical evidence concerning the worker's condition came about in an unusual way. The worker was assessed by an impairment panel pursuant to s71 *Work Health Act*. Effectively the report of the panel comprising a report from Dr Reid and Dr Burns (two reports from Dr Burns) conclude that his impairment, being the painful heel is not work related. The question of impairment is a different question to the question of incapacity within the meaning of the *Work Health Act*, however these reports have been relied on by the employer to inform on the question of relationship between the current condition and the injury sustained out of in the course of employment. As indicated in the introduction to these reasons, three of the reports were attached to the Form 5 with a letter from the employer's solicitor. The reports amount to strong medical opinions however in my view the process adopted by the employer falls short of what is required by s69(3), namely that the Statement of Cancellation "shall be accompanied by the medical certificate of the medical practitioner certifying that the person has ceased to be incapacitated for work". As has often been stated, s 69 requires strict compliance: *CEG Ansett Australia v Nieuwmans* (1999) 9 NTLR 125, *Collins Radio Constructions Inc v Day* (1997) 140 FLR 347. Both parties agree that *NT TAB Pty Ltd v Gail Dickin* [2004] NTCA 8 admits a more flexible approach. I note however that *Dickin* concerned interpretation of s69(4) concerning the sufficiency of the reasons. In my view, although the medical practitioners whose reports have been attached to the Form 5 express strong opinions about impairment and the lack of connection with the injury, it is simply not "certifying" that the worker is incapacitated for work. Given the mandatory nature of s69(3) I am of the view that there has been non-compliance. I agree with the submission that

"certifying" brings a degree of firmness and clarity to what may otherwise be regarded as an opinion. It is true that the employer at a later time (although it is not completely clear when), forwarded a certificate pursuant to s69(3) *Work Health Act* to the worker's solicitor. The certificate is dated the 16th June 2005 and confirms that as at 22nd March 2005 the worker ceased to be incapacitated for work because of the original injury. Although I agree that for most purposes service of a document in Work Health cases may be served on a legal practitioner: (*Work Health Rules* part 4; in particular Rule 4.06), in my view what has occurred in these proceedings is not what is contemplated by s69(3). I toyed with the idea during proceedings of possibly regarding the forwarding of the certificate to the worker's solicitor as completion of what was required under s69(3), however on reflection in my view it is clear that the section means that the appropriate certification be served on the worker at the time the reasons for cancellation are served.

59. It is somewhat of an unusual situation where I have come to this conclusion after hearing the evidence, however in my view I must go on and deal with the issue of the counterclaim.

Validity of the Counterclaim

60. Counsel for the Worker mounted a spirited attack on the validity of the counter-claim. I leave aside for the moment the issue of the *estoppel* argument/amendment by addition that I will deal with later. The particulars of the counter-claim are as follows:

    1. The employer repeats and relies on the matters sent out in paragraphs 2 and 3 of the Defence to the Statement of Claim.

    2. As at 12 August 2004, the worker was suffering a painful left heel which was not a work related condition.

3. As at 12 August 2004, the worker had ceased to suffer any incapacity for work by reason of any work-related injury or condition.

4. In the alternative, as at 22 March 2005, the worker was suffering a painful left heel which was not a work related condition.

5. As at 22 March 2005 the worker had ceased to suffer any incapacity for work by reason of any work-related injury or condition.

6. In the alternative, as at 27 July 2005, the worker was suffering a painful left heel and abnormal illness behaviour, which were not work-related conditions.

7. As at 27 July 2005, the worker had ceased to suffer any incapacity for work by reason of any work-related injury or condition.

AND THE EMPLOYER CLAIMS

a) A declaration that the worker has no entitlements to compensation on and from 12 August 2004.

b) An order for reimbursement of benefits paid pursuant to the Act since 12 August 2004.

c) Alternatively, a declaration that the worker has no entitlement to compensation on and from 22 March 2005.

d) Alternatively, an order for reimbursement of benefits paid pursuant to the Act since 22 March 2005.

e) Alternatively, a declaration that the worker has no entitlement to compensation on and from 27 July 2005.

f) Costs of and incidental to this counter-claim.

61. The *Defence to the Counter-claim* is as follows:

1. The Worker refers to and repeats the facts pleaded in paragraphs 2 and 3 of the Statement of Claim.

2. The Worker denies that he was only suffering from a painful left heel condition as at 12 August 2004 or alternatively as at 22 March 2005, as alleged in paragraphs 2 and 4 of the Employer's Counterclaim and he further denies that the said condition was not work related.

3. The Worker denies that the effects of the injury he suffered referred to in paragraph 2 of the Statement of Claim, had ceased to incapacitate him for work after 12 August 2004 or alternatively after 22 March 2005, as alleged in paragraphs 3 and 5 of the Employer's Counterclaim.

4. The Worker admits paragraph 6 of the Counterclaim save that he denies that his painful left heel condition and abnormal illness behaviour were not work related.

5. The Worker denies that he had ceased to suffer any incapacity for work by reason of any work related injury or condition as at 27 July 2005, as alleged in paragraph 7 of the Employer's Counterclaim.

6. The Worker denies that the Employer is entitled to the declarations and relief sought at paragraph 7 of the Employer's Counterclaim, or any relief at all.

7. The Worker seeks that the Counterclaim be dismissed and that the Employer pay his costs and incidental to the Counterclaim.

62. It was submitted that the counter-claim did not comply with Rule 9.05(2) Work Health Rules that reads:

> 9.05 Counterclaim
>
> (1) If –

(a) an employer served with a statement of claim has a claim against the worker; or

(b) a respondent served with a statement of claim has a claim against the applicant,

he or she may counterclaim in the proceeding by completing the part of the notice of defence that relates to a counterclaim.

(2) A counterclaim is to contain –

(a) a concise statement of the nature of the claim;

(b) particulars of the claim; and

(c) a statement of the relief or remedy sought.

(3) The pleadings in a counterclaim are to comply with Part 8 but a failure to comply does not invalidate the counterclaim.

(4) These Rules apply to and in relation to a counterclaim as if –

(a) a reference in these Rules to a party who is the employer or respondent were a reference to the worker or applicant; and

(b) a reference in these Rules to a party who is the worker or applicant were a reference to the employer or respondent

63. The decision of *James Barclay v TNT Australia Pty Ltd* 12 September 2003, Her Honour Ms Little SM was relied on. There Her Honour fount the counter-claim in question did not comply with the Work Health Rules as there was no allegation of a claim or an entitlement to some relief or remedy. Her Honour also noted there was no allegation of a cross claim which, by law, the employer is entitled to raise and have disposed of, in the action brought by the worker. These matters turn on the particular context of their cases. There have been a number of developments in this area of the law and although I had some uncertainty at the time of the hearing, it now appears to me that the law has developed to the point of allowing counter-claims and relief of the type filed in these proceedings. For example, recently His Honour the Chief Justice in *Swanson v Northern Territory*

Australia [2006] NTSC 88 has determined that *Work Health Rule 9.05* is a valid Court rule enabling a respondent to defend the claim on grounds other than those related to the s69 appeal. Many of the arguments raised in this part have been dealt with by the Supreme Court in *Swanson.*

64. Concerning the argument that the counter-claim is invalid by virtue of s104 *Work Health Act* governing claims under Part V of the *Work Health Act* and the application of s103J, His Honour in *Swanson* stated:

> "[33] Section 104 governs the commencement of proceedings for "the recovery of compensation" or "an order or ruling in respect of a matter or question incidental to or arising out of a claim for compensation" under Part V of the Act.
>
> [34] The commencement of proceedings pursuant to s 104 is subject to the requirement in s 103J that "a claimant is not entitled to commence proceedings" under s 104 in respect of a dispute unless there has been an attempt to resolve the dispute by mediation and that attempt has been unsuccessful. A "claimant" is defined as a person "claiming or being paid compensation". Section 103J does not apply to an employer.
>
> [35] Finally, it is appropriate to refer to s 110A which provides that the procedure in respect of proceedings commenced under s 104 is, subject to the Act, Regulations, Rules and practice directions, within the discretion of the Court. Section 110A(2) states that the proceedings shall be conducted with as little formality and technicality "as the requirements of this Act and a proper consideration of the matter permits"."

65. In relation to the validity of Work Health Rule 9.05, His Honour with respect emphasized the purpose of the rule making power within the *Work Health Act* to ensure that all outstanding issues between the parties are aired and determined in the one set of proceedings. With respect I adopt and of course am bound by His Honour's reasoning that in my view answers the argument asserted on behalf of the worker in this matter.

> "[36] Rule 9.05 is one of a number of rules dealing with the form of pleadings, including r 8 which is the general rule governing the content and form of pleadings. Rule 8.02(1) authorises a party to

include in a pleading a “counterclaim against any other party to the proceeding”. In a plain indication that one of the purposes of the rules is to enable the Work Health Court to determine all issues between the parties in the one proceeding, r 8.02(2) provides as follows:

“(2) To enable the Court to determine all issues in dispute, a party may plead additional facts or matters to those raised in an application, an appearance or a decision made under section 69, 85 or 86 of the Act.”

[37] Part 9 of the Rules is specifically directed to the pleadings by way of statement of claim, notice of defence and counterclaim. Division 1 containing r 9.01 relates to statements of claim and the information required in that pleading. Rule 9.03 and r 9.04 direct that a party served with a statement of claim must file and serve a notice of defence which is to be in accordance with the prescribed form and to contain “a concise statement of the defence or defences relied on” and “particulars of each defence”. The relevant form instructs that the party defending the claim “must insert all the material allegations of fact (but not the evidence)” on which the party relies in defending the claim and making the counterclaim (if applicable).

[38] Rule 9.05 has been in operation since 1 August 1999 and provides for pleading by way of counterclaim:

“9.05 Counterclaim [Note – His Honour set out Rule 9.05]

[39] The essence of the appellant’s submission as to the invalidity of r 9.05 was set out in the written outline of submissions in the following terms:

“The rule making power is to be found in s 95 of the Act. Rule 9.05.02 is inconsistent with the legislative scheme and impinges upon a substantive right to a degree that fails the ‘reasonable proportionality’ test of validity. See discussion in Taylor v Guttilla (1992) 59 SASR 361 at pp 366 – 368 per King CJ. The remarks of Mildren J in Disability Services v Regan (1998) 8 NTLR 73 at p 78 are obiter and the decision is distinguishable on its facts.”

[40] At the time that Disability Services was decided, there was no provision in the Rules for a filing of a counterclaim. The Court of Appeal made a suggestion that the deficiency should be rectified (78):

"Before leaving this appeal, it is desirable to mention briefly two other matters which were raised in argument ……. The second matter is that the Work Health Court Rules 1987 (NT) do not contemplate, and made no specific provision for, a counterclaim. In this case, the appellant sought in its answer to recover payments of compensation already made. The learned Chief Stipendiary Magistrate, although finding for the employer, did not consider this claim. This is not the subject of complaint here, but it illustrates a weakness in the Work Health Court Rules 1987 (NT) which perhaps should be addressed. It is understandable that, in proceedings in the Work Health Court, the parties will usually wish to litigate all outstanding issues. An employer who has served a s 69 notice, may subsequently decide after the employer has appealed, that the issues to be decided upon the appeal are too narrowly confined. At present, if the employer is in this position, the employer can bring its own substantive application and apply to have the two applications heard together. It may simplify hearings procedurally and focus proper attention on who bears the onus of proof if the Rules were amended to permit the employer to raise new issues by way of counterclaim."

[41] It is evident that the Court in Disability Services did not consider that rules providing for the filing of a counterclaim would be beyond the rule-making power found in s 95. However, that specific issue was not argued.

[42] I am unable to discern any reason why Rule 9.05 is invalid. A counterclaim is a recognised form of pleading which enables all outstanding issues between the parties to be raised in the one set of proceedings, including any claim that a respondent might assert against a plaintiff as opposed to merely a defence to the plaintiff's claim. A counterclaim is precisely the type of procedure contemplated by s 95.

[43] There is nothing in the terms of s 69 or any other provision of the Act which would exclude from the rule-making power in s 95 a power to make rules providing for the filing of a counterclaim in order to ensure that all outstanding issues between the parties are aired and determined in the one set of proceedings. Nor is the provision for a counterclaim and disposal of all outstanding disputes in the one proceeding precluded by the legislative scheme. Such provision in the Rules does not undermine any purpose of the legislative scheme.

[44] Counsel for the appellant referred to the decision of the South Australian Full Court in Taylor v Guttilla (1992) 59 SASR 361. The Court was concerned with a Local Court Rule which provided that

each party deliver to any other party a full and true copy of every medical report received by the party or the party's solicitor relating to any injury or illness referred to in the pleadings upon which medical evidence might be relevant. The Court held that the rule was ultra vires the rule-making power because it destroyed the substantive right of legal professional privilege.

[45] In the course of his judgment, King CJ made the following observations (365):

"It is necessary to determine the true character of the Rules. If, properly understood, it complies with the description of the authorised subordinate legislation, it is within power. It is therefore, as the Court held in Cleland v Boynes, a problem of characterisation. Subordinate legislation cannot, in the absence of express statutory power, repeal or amend a statute but, subject to that, if the Rule under consideration is properly characterised as one regulating pleading practice or procedure, there is no reason in principle why the fact that it affects incidentally a legal right which would otherwise exist, should result in invalidity." (my emphasis).

[46] King CJ noted that the existence of effect upon substantive rights is "not necessarily determinative of validity" (366) and identified the "difficulty in any particular case" as determining "whether the Rule has passed so far into the field of substantive law as to have lost its procedural character". His Honour continued (367):

"The criterion for judging whether intrusion into substantive law or effect on substantive rights has deprived a Rule of its ex facie procedural character, which will be found most useful in the generality of cases, is that of proportionality."

His Honour then cited the following passage from the joint judgment of Wilson, Dawson, Toohey and Gaudron JJ in South Australia v Tanner (1989) 166 CLR 161 at 165:

"In the course of argument, the parties accepted the reasonable proportionality test of validity (cf Deane J in Commonwealth v Tasmania (the Tasmanian dam case)), namely, whether the regulation is capable of being considered to be reasonably proportionate to the pursuit of the enabling purpose."

[47] Ultimately, King CJ concluded that the rule "directly abrogated" legal professional privilege with respect to a wide class of documents "disengaged from any connection which they might have with

evidence to be given in the case" (367). His Honour classified the rule as amounting to an "invasion of the substantive right" which was "direct and substantial" (368). In those circumstances, King CJ was of the view that the rule could not be regarded as "reasonably proportionate to the pursuit of the enabling purpose, namely the regulation of pleading practice or procedure" (368).

[48] Pressed to identify a substantive right adversely affected by r 9.05, counsel for the appellant was unable to identify any such right other than what he described as a "right to mediation" pursuant to s 103J. As I have said, that section provides that a "claimant" is not entitled to commence proceedings under Div 2 in respect of a dispute unless there has been an unsuccessful attempt to resolve the dispute by mediation. Section 103J is a procedural provision which requires the parties to undertake mediation before a worker is entitled to commence proceedings, including an appeal against a cancellation of payments pursuant to s 69. That mediation occurred. Assuming that s 103J confers a substantive right for present purposes, an assumption of doubtful validity, r 9.05 does not adversely affect that right. Rule 9.05 operates after the unsuccessful mediation and after the commencement of the proceedings at a stage in the proceedings when the operation of s 103J is spent and it has no application.

[49] Rule 9.05 is a procedural rule of the type contemplated by s 95. It does not impinge upon a substantive right and is "reasonably proportionate to the pursuit of the enabling purpose, namely the regulation of pleading practice or procedure"."

66. Similarly, in my view, the argument that the counter-claim is not a true claim within the contemplation s104 *Work Health Act* has been rejected in *Swanson*, and is a similar situation to that contemplated here. In my view the counter-claim is validly brought and complies with the Work Health Rules and I refer again to His Honour's reasoning in *Swanson:*

"[50] In association with the general complaint that the Magistrate erred in entertaining the Counterclaim, the appellant submitted that the respondent's pleading "was neither a substantive claim pursuant to section 104 of the Act nor a true counterclaim". In essence the appellant contended that the pleading consisted only of denials and operated only as a defence. According to this contention, the pleading sets out no claim in substance and seeks only a declaration which is not a substantive remedy or relief.

[51] Rule 1.08 defines a counterclaim as "meaning a claim in a proceeding" by an employer against a worker or by a respondent against an applicant. Rule 9.05(2) provides that a counterclaim is to contain a concise statement of the nature of the claim, particulars of the claim and a statement of the relief or remedy sought.

[52] The "Notice" of Defence and Counterclaim filed by the respondent denied that the appellant suffered the injuries pleaded in para 3 of the Statement of Claim and, in the alternative, asserted that if the appellant suffered an injury it arose as a result of reasonable administrative action. A number of other assertions of fact were pleaded. In para 10 the respondent denied that the appellant was entitled to any compensation. In para 11 the respondent identified that it was seeking "the following declarations and orders". In substance the "relief or remedy" that the respondent sought was pleaded, namely, a determination that if the appellant suffered a mental injury it was the result of reasonable administrative or disciplinary action on behalf of the respondent and was, therefore, not a compensable injury. This was a claim by the respondent against the appellant and the remedy sought was relief from the liability to pay compensation to the appellant.

[53] The fundamental purpose of pleadings is to assist in the fair and efficient administration of justice. By it's pleading, the respondent plainly identified the issues in dispute and the material facts upon which it relied. The pleading also plainly identified that for reasons specified in the pleading, independently of the questions arising under s 69, the respondent sought a determination that it was not liable to make payments of compensation. The respondent advanced a substantive claim which could stand on its own and which was properly placed before the Court by way of counterclaim. In addition, whether the "Notice" is viewed as a defence or counterclaim or both, it was more than adequate for the purposes of raising the issues in dispute and identifying the material facts on which the respondent relied and the remedy sought. This complaint flies in the face of s 110A(2) by endeavouring to rely upon a technicality. Independently of s 110A(2), the complaint is devoid of merit."

Declaratory Relief

67. As in *Swanson*, the Court in these proceedings has been asked to make a declaration (as set out in the pleadings noted above). As in *Swanson* counsel for the worker submitted that the Work Health Court has no jurisdiction to grant declaratory relief. Counsel argued there is no specific power in

contrast with s14(8) *Local Court Act* providing the Local Court may "make a binding declaration of the rights of the party or parties of the claim". His Honour found it was unnecessary to decide whether, as a matter of law, the *Work Health Court* possessed the necessary jurisdiction to make a "declaration". At first instance Ms Little SM made a finding concerning reasonable administrative action and made no distinction between a ruling and a declaration. On Appeal His Honour noted the concession that the issue was of no practical consequence.

68. I have indicated I have made certain relevant findings. As to whether a declaration can be made as a matter of law on the same subject matter is still an open point. As the declaratory relief is part of the pleadings I need to make a ruling on it. In my view, given the *Work Health Court* is a *court of record* (albeit an inferior court of record; s93 *Work Health Act),* and given it has power to hear and determine claims for compensation under Part V and questions *incidental* to or arising out of such claims, I have concluded the *Work Health Court* possesses the necessary power to make declarations as a necessary incidental to the proper exercise of jurisdiction and to enable it to fulfil its statutory functions. Many of the "findings" made in the *Work Health Court* are in the nature of declarations as they define the rights and obligations of parties as a matter of law unless and until there is a further order made. For example, a finding that a person is entitled to compensation under the Work Health Act is in effect a declaration under the Act on their entitlements. I am reminded that the *Work Health Court* is a creature of statute and as such its powers are prescribed by the statute. A statute establishing a Court with incidental powers includes, in my view, the powers necessary for the Court to function as a Court proper and by necessary implication the Work Health Court must possess the power to make declarations to function even if traditionally they have been called "findings" (I have been influenced in these views generally by Crawford and Opeskin, "Australian Courts of Law", (Oxford University Press) chapters 5,

6, 8, 11 and Covell and Lupton, “Principles of Remedies”, Chapter 11, (Butterworths). I note this is the approach taken by the New South Wales Compensation Court in *Allison McEvoy v Southern Cross Homes (Broken Hill) Inc*, Ashford J, 22 June 2001 and *Lupton & others v Better Care Pty Ltd & Others* (1996) 13 NSW CCR 246, Bishop J, 28 June 1996. I note the various claims for re-imbursement are not pursued and I do not intend to make orders for re-imbursement.

Estoppel

69. At the commencement of this hearing I allowed the employer to add estoppel to the filed defence. I had thought that counsel for the worker resisted the substance of the argument but not the filing or amendment by addition. There was a deal of confusion about this at the end of the hearing and having now viewed the earlier transcript, I see that counsel and I were at cross-purposes and he indeed may have been of the belief that I was not going to permit the amendment whereas I thought that I had. It is regrettable that I was not clear in our discussion on that matter. I have considered the estoppel argument but I reject it. The additional pleading reads as follows:

> “2(vi) The worker is estopped from asserting that his left leg and foot pain are work-related.
>
> Particulars of estoppel
>
> (a) On 12 August 2004, the worker was examined by a medical panel for the reassessment of permanent impairment found by Dr A Cohen.
>
> (b) On 30 August 2004, the panel chaired by Associate Professor R J Burns issued a report determining that the worker was not suffering from any impairment which was work related.
>
> (c) The determination of the panel is binding and not open to review, in particular the panel determination that the left heel and foot pain experienced by the worker is not related to a work injury.”

70. It may be recalled this worker was examined by an impairment panel and it appears as a result of that examination the process of commencing action to cancel payments commenced. Section 72 *Work Health Act* provides as follows:

> **"72. Assessment of permanent impairment**
>
> (1) [Omitted]
>
> (2) The level of permanent impairment for the purposes of section 71 shall be assessed in the first instance by a medical practitioner.
>
> (3) Where a person is aggrieved by the assessment of the level of permanent impairment by a medical practitioner, the person may, within 28 days after being notified of the assessment, apply to the Authority for a reassessment of that level.
>
> (3A) Subject to subsection (3B), the Authority must, as soon as practicable after receiving an application, refer the application to a panel of 3 medical practitioners to reassess the level of permanent impairment.
>
> (3B) The Authority is not required to refer an application to a panel unless satisfied that the assessment was properly conducted and is in accordance with the guides prescribed for the purposes of the definition of "permanent impairment" in section 70.
>
> (3C) The panel to whom an application is referred –
>
> (a) must include at least one medical practitioner appearing to the Authority to have specialist knowledge of the type of impairment in question; and
>
> (b) must not include the medical practitioner who originally assessed the level of impairment.
>
> (4) An assessment made by a panel under subsection (3A) as to the degree of permanent impairment of a worker –
>
> (a) is taken to be the level of permanent impairment suffered by the worker for the purposes of section 71; and
>
> (b) is not subject to review.
>
> (5) The costs incurred in carrying out an assessment or reassessment under this section shall be paid by the employer".

71. The employer relies primarily on s72(4)(b) that the decision “is not subject to review”. There are numerous and diverse reasons not to accept this argument. In my view to interpret s72(4)(b) is such a way is at odds with the fundamental structure of the *Work Health Act*. There are procedural and substantive provisions to be complied with when an employer seeks to cancel benefits; it is permissible in those circumstances for a worker to challenge medical evidence before the Court quite separately and apart from s72 considerations. In my view s72(4)(b) is directed at the level of impairment even noting that “impairment” relates back to the “injury”; however the prohibition of review is directed to the *level* of impairment. Taking ss71 and 72 *Work Health Act* together, it does not appear to attempt to cover the more fundamental question of the origin of the injury.

72. If I am wrong in that conclusion, in any event, in my view s72(4)(b) cannot be construed in such a way to defeat the processes within the elaborate legislative regime of the *Work Health Act* concerning incapacity, payments, cessation of payments and other subject matter for which findings may be made. The approach would render the application of the *Work Health Act* redundant in many circumstances. This has not been a proceeding “reviewing” the assessment of the panel. The various opinions of panel members have, as it turns out, provided the evidential material on which the employer relies, both in the s69 cancellation and the counter-claim. In this forum it is subject to challenge, unlike the setting of the panel. The statute provides it should be so.

73. I have been referred to *Port of Melbourne Authority v Anshum Pty Ltd* (1981) 36 ALR 3 concerning the principles of *res judicata* and *issue estoppel*. In my view it is not a case of attempting to re-litigate an issue previously determined, whether in whole or in part. Leaving aside the question of construction of the *Work Health Act*, the situation of a panel is not a context contemplated by the principles of *res judicata* or *issue estoppel* that traditionally apply to court proceedings or at least more formal

tribunals or quasi judicial bodies where issues are formally agitated. Although I permitted this issue to be argued even though it was filed late in the day, I would dismiss the defence based on estoppel. As an ancillary matter, in my view the Court is in the dark on whether it has the basis and total evidential material concerning the panel's findings. Those matters have not been properly proven and are deficient to prove that there has been a determination according to the *Work Health Act*.

Formal Matters

74. I have made various findings throughout the course of these reasons. I will forward a copy of this decision to the solicitors for the parties today and list the matter on 8th December 2006 at 10.00am for the purpose of making formal orders and hearing any issues concerning cost.

On 8th December 2006 at 10.00am, I intend to make the following orders:

1. The Notice sent by the employer to the worker dated 4 April 2005 purportedly in compliance with s69 *Work Health Act* is invalid.

2. The counterclaim is allowed in part in that: The Court finds and declares that as at 12 August 2004, the worker has ceased to suffer any incapacity for work by reason of any work-related injury or condition and has no entitlement to compensation on and from 12 August 2004.

Final Orders

75. On 12 December 2006 Ms Robinson appeared for both parties and the Court made the following orders:

1. The Notice sent by the employer to the worker dated 4 April 2005 purportedly in compliance with s69 *Work Health Act* is invalid.

2. The counterclaim is allowed in part in that: The Court finds and declares that as at 12 August 2004, the worker has ceased to suffer any

incapacity for work by reason of any work-related injury or condition and has no entitlement to compensation on and from 12 August 2004.

3. I make no order as to paragraphs B, C, D and E of the Counterclaim.

4. The worker's claim for weekly payments of compensation to be reinstated is dismissed.

5. The Court makes no order for costs today and notes that the parties are negotiating the matter and leave is granted at reasonable notice to either or both parties to make application for costs at some time in early 2007.

Dated this 4th day of December 2006.

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Jenny Blokland
CHIEF MAGISTRATE