CITATION: *Cheryl Newton v Masonic Homes Pty Ltd* [2008] NTMC 059

PARTIES:	CHERYL NEWTON
	v
	MASONIC HOMES PTY LTD
TITLE OF COURT:	Work Health Court
JURISDICTION:	Work Health
FILE NO(s):	20718189
DELIVERED ON:	27 August 2008
DELIVERED AT:	Darwin
HEARING DATE(s):	7 - 11 July 2008, 17 July 2008
JUDGMENT OF:	Relieving Magistrate Fong Lim

CATCHWORDS:

Work Health – Validity of notice to terminate -total incapacity – partial incapacity – consequential injuries – complex regional pain syndrome – psychiatric diagnosis – reliability of expert evidence – evidential burden – section 65 (2)(b)(i) & (ii), s 68, s 69

Ansett v Niewmans 9 NTLR 125
Robert Hicks v Bridgestone 29 May 1997 NT Court of Appeal, unreported
Collins Radio Constructions Inc v Day [1997] 140 FLR 347

REPRESENTATION:

Counsel:

Plaintiff:	Ms Gearin
Defendant:	Ms Kelly

Solicitors:

Plaintiff:	Ward Keller
Defendant:	Hunt & Hunt

Judgment category classification:	C
Judgment ID number:	[2008] NTMC 059
Number of paragraphs:	212

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

No. 20718189

[2008] NTMC 059

BETWEEN:

CHERYL NEWTON
Plaintiff

AND:

MASONIC HOMES PTY LTD
Defendant

REASONS FOR DECISION

(Delivered 27 August 2008)

Ms FONG LIM RSM:

1. The Worker's application originally came before this Court before Mr Trigg in March of 2008 and was unfortunately subject to an aborted hearing after 3 days of evidence. The second hearing took place on 7 –11 July and 17 July 2008.

2. On 14April 2005 the Worker was injured while undertaking her duties as personal care assistant at the Tiwi Gardens Aged Care facility run by the Employer. There is no dispute that on that day the Worker suffered a ligamentous injury to her right thumb which required surgery in late 2005. The Employer paid the Worker weekly benefits, her medical and rehabilitation expenses up until 17 May 2007 when a Notice of Intention to cease payment of benefits was served on the Worker. Prior to the Notice being served the Worker claims that she had given notice to the Employer of alleged consequential injuries to her left arm and her mental state. The notice of those alleged consequential injuries are denied and the Employer also puts in issue the Worker's failure to serve a claim form for the alleged

consequential injuries. The validity of the Notice of Intention to cease payments is in contention as is the certification of the Worker's fitness for work by Drs Haynes and Goodhand.

3. The Employer also disputes the Worker's continued incapacity for work partial or total arising out the original injury to her right thumb.

4. The Worker also claims reimbursement for the purchase of a new car and for reimbursement of travel expenses to and from medical appointments which she claims in her pleadings were underpaid.

5. The Worker also claims payment for some hours of home care assistance.

6. Normal weekly earnings of the Worker have been agreed at $535.80 gross per week indexed to 2008.

7. The Worker called evidence from herself, her friend Mr Bond, several doctors and health professionals. The Employer called evidence from three doctors, an assistant school principal, receptionist and pharmacy assistant trainer. The Employer also put into evidence some labour market research as to the average weekly earnings for certain occupations.

8. The Worker's evidence in chief consisted of a recitation of her work history and the duties of each of the jobs she had done in the past, confirmation of the medication she was presently taking, the treatment she has received in the past three years, involvement in rehabilitation including attempts to return to work and the progression of her symptoms. She also explained the difficulties she has had regarding driving and the necessity to purchase a new car. She gave no evidence of her present mental or emotional state and how that affects her ability to work. She did give evidence of being forgetful and slower in completing physical tasks such as housework.

9. Mr Bond's evidence was corroborative in nature in relation to how he and the Worker share household duties and his involvement in the Worker's

decision to buy a new car. Mr Bond was a mechanic by trade until an injury disabled him from work. In cross examination he gave evidence about the comparison between the vehicle previously owned by the Worker and the reasons why he advised her to purchase the one that she did.

10. All of the doctors called were referred to their reports and those reports were tendered in evidence. Cross examination of the doctors (whether called by the Worker or the Employer) concentrated on the methodology used by that doctor to come to the conclusions that they did. Some were questioned on their expertise in their field and others' reliability as an expert was brought into question. There were of course varying opinions of the causes of the Worker's various ailments.

11. The Employer's primary case is that, even accepting all of her stated limitations the Worker still has a capacity to work in an occupation which will nett her more than 75% of her Normal Weekly Earnings (this is their counterclaim). The Employer also submits that the Worker's development of symptoms in her left arm and continuing symptoms in her right arm are an exaggeration of her disability. The Employer submits the Worker's symptoms cannot be explained by any acceptable medical diagnosis and therefore the Worker must be feigning her symptoms. It is also submitted on behalf of the Employer that any psychiatric or psychological condition the Worker may have is not causally linked to injury to the right thumb.

12. Worker's submission is that it doesn't really matter what the diagnosis of her condition is, if I am satisfied the symptoms in the right and left hands and the psychological condition exist and they are causally linked to the injury to the right thumb, then I should be satisfied that she is entitled to benefits (see *Ansett v Niewmans* 9 NTLR 125, Robert *Hicks v Bridgestone Australia Ltd* 29 May 1997 NT Court of Appeal unreported).

13. I accept that reasoning however it is my view that I cannot find on the balance of probabilities that the symptoms and conditions exist unless there

is a reasonable acceptable medical reason for them, whether it is physical or psychological, and the worker is not feigning or exaggerating her symptoms.

Evidence of Injury and Development of Symptoms

14. The Worker's description of her symptoms as they presently are include, occasional red and splotchiness in the colouring of her hands, constant ache in both her wrists and the base of her thumbs, burning sensation and sweatiness of her palms. The Worker also complains of regular swelling in both hands and constant pins and needles in both hands. She also complains of a strange sensation in her right elbow but states that she does not presently have elbow or shoulder problems on her left side.

15. At one stage while giving evidence she indicated that the redness was happening and her hands were displayed for the Court to inspect – the discolouration was not clear to me on that inspection. Photos were also supplied of the Worker's hand which apparently showed a previous occasion when the hands were discoloured however there was no evidence of the normal colour of the Worker's hand so this evidence was not helpful.

16. The Worker confirmed that her pain gets worse with activity and it takes her a lot longer to undertake household tasks than it did before the original injury. She also asserts that her condition has not improved over the last 18 months – 2 years.

17. Dr Goodhand is the Worker's treating general practitioner and is the doctor who has certified her as totally incapacitated for work except for one period where he approved a limited return to work program. Dr Goodhand's opinion of the Worker's ability to return to work is as expressed in his report of 8 May 2007:

> "Mrs Newton's capacity to engage in meaningful employment is extremely limited, both from the perspective of her physical capacity and her work tolerance in that she would only be able to work limited

hours on a daily basis and even then may require time off for exacerbation of her symptoms".

18. Dr Goodhand accepted the Worker's history that she was suffering symptoms in her left arm as a result of her inability to use her right hand properly and attributes her left arm problems to overuse arising out of limited use of the right arm. Dr Goodhand suggested that the problems in the left arm could have been caused by an aggravation, through overuse of the pre–existing degenerative arthritic changes in the shoulder. He does accept that the extent of symptoms complained of by the Worker presently cannot be explained physiologically.

19. Dr Walton, psychiatrist, gave evidence that he had accepted the history provided to him by the Worker and that he observed nothing in his session with the Worker to contradict the history provided. He diagnoses the Worker as having Chronic Adjustment Disorder with mixed anxiety. Dr Walton was criticized by the Employer for the form of his report and the lack of explanation of his methodology of how he reached his conclusions. If the Worker's action had been in common law I may have disallowed the admission of the report however I allowed the evidence on the basis that I would consider the weight I place on the report when considering all of the evidence. Dr Walton expresses an opinion that:

> "The current situation is that there probably is an adverse interaction between the physical pain and the depression, each tending to aggravate and perpetuate the other".

20. He prefaces that opinion with a broad statement that:

> "<u>It is hardly a matter of psychiatric expertise</u> that persons suffering from disabling pain develop emotional disturbance. It would be uncommon and almost abnormal if they did not do so. The dysphoric component of pain and the limitations it imposes are routinely demoralising and, especially if the picture is one of chronicity, such as persons slowly ground down by the pain, often with the development of clinically significant depression".

21. Dr Walton seems to misunderstand his role in providing his report and that is to provide the Court with his "psychiatric expertise". Whether he has done that will be discussed later.

22. Evidence of Mr Alan Bond corroborated the Worker's evidence of her restrictions in relation to the household duties they share. He accepted she had her good days and her bad days. His evidence is that he also has problems regarding his back and has had to adjust the way he does things, yet he does most of the household duties. He did not really elaborate on what he says those duties were except to refer generally to cooking, cleaning and gardening (although he is restricted in what he can do in relation to heavy lifting). Mr Bond confirms that the bigger jobs such as fans and louvres they rely on their grown up children to help out.

23. A lot of Mr Bond's evidence related to the purchase of a car for the Worker and why it was decided to buy a new model automatic instead of an older vehicle. There was evidence of the red book values of the vehicle the Worker had before her injury (a manual) and the value of the equivalent (same age and model) vehicle.

24. Mr Bond went on to give the opinion that it would not have been worth converting the Worker's old car to an automatic because the cost of an automatic transmission was too expensive and he didn't want to risk spending that amount of money on a conversion if the car, given its age, was to have mechanical problems. His evidence on this aspect is a little contradictory because on the one hand he says that there is nothing wrong with the Worker's original vehicle, it is still going strong with regular servicing, and on the other hand he is of the opinion that a couple of years ago it was too risky to do a conversion.

25. Dr Flavell, a specialist in rehabilitation medicine since 1986, then gave evidence. He saw the Worker on 30 September 2005 and the symptoms described to him were:

- Burning sensation in right thumb and feeling of heat;
- Shooting pain which travels up her right arm to her neck and shoulder;
- Her right hand sweats more than her left;
- Colour changes in her right hand;
- Some pain in her left arm;

26. Dr Flavell's examination revealed:

> "swelling around the base of her thumb. Her right palm was sweaty and her right hand was paler than her left. She had a restricted range of thumb flexion which I think involved all the joints of her thumb".

27. The doctor recommended bone scans and suggested that the worker be given some professional emotional support and perhaps some behaviourally based pain management. It is clear from the doctor's first report of 5 October 2005 that he was still in the investigative stages of his treatment of the Worker.

28. In his report of 25 October 2005 the doctor had the benefit of the results of the bone scan he had recommended take place. The bone scans showed:

- Symmetrical vascularities to both hands not in keeping with the presence of reflex sympathetic dystrophy;
- Arthritic process in the scapho-trapezium –trapezoid articulation on the right hand;
- Moderately prominent arthritic changes in the distal interphalangeal joints of the 2nd and 5th digits in the right and left hand.

29. Dr Flavell's conclusion was that the Worker's injury to her thumb had caused an aggravation to her arthritic joints and that there may be some autonomic condition developing. He also suggests that the worker needed to be mindful of creating problems with her left arm through overuse.

30. The Court then received evidence from Dr Champion. The doctor was presented as a specialist in pain medicine which he indicated became a recognised medical speciality about two years ago. The doctor is a Rheumatologist who has practiced in pain medicine for the past 20 years. Dr Champion explained the reason for the recognition of the need for a specialty in this area is because it was recognised that more knowledge is required in this area. He explained pain medicine was a field which considered Musculoskeletal, Rheumatological, Neurological and Psychiatric causes and treatment of pain.

31. Dr Champion saw the Worker in May 2008 and was provided with an extensive history of the Worker's symptoms and attendances on other doctors by Ward Keller, the solicitors for the Worker. He also undertook some clinical tests and examinations of the Worker's hands. The Worker's symptoms were reported as:

> "…. a dull throbbing pain in her right thumb, especially round the metacarpophalangeal joint region, dull throbbing pain anteriorly at the right wrist, and pins and needles in the right middle, ring and little fingers. On the left side there was a similar dull, throbbing sensation in her left thumb, same thing anteriorly at the left wrist, and intense pins and needles involving all five digits, generally more intense that on the right side. It seemed that many of the symptoms were in mirror image on the two sides, and she was inclined to agree that seemed commonly the case, and overall the right upper limb and left upper limb disability is about equal. The main difference between the two sides was the relative prominence of pins and needles and numbness in the left more than the right thumb and index finger (minor only on the right side). I observed osteoarthritis change in the distal interphalangeal joints, of long standing, and these disorders appeared not very symptomatic. Involvement was bilateral, especially involving index and middle fingers.
>
> At the right 1st carpometacarpal joint there was pain on active and passive movements and tenderness to palpation, consistent with reasonably aggressive osteoarthritis. There were similar but milder signs/responses to examination on the left side".

32. Those observations combined with an analysis of the reports of other doctors, the investigations undertaken, his own clinical examinations and accepting the Worker's description of her symptoms, led the doctor to the following conclusions:

> "I acknowledge the difficulty in satisfactory explanation and acknowledge that the evolution of the left arm and hand disorder has been perplexing.
>
> (*the operation on the thumb)* has had no real beneficial influence on the chronic regional pain and upper limb dysfunction.
>
> The probable causes of the diminished grip strength *(included)* flexor tenosynovitis , ... secondary allodynia and peripheral neuropathic features..... Post–injury psychological factors may have contributed also.
>
> I do not consider she currently meets criteria for bilateral upper limb CRPS Type I, but concede that she has quite a number of the relevant features and may well have met some criteria at an earlier stage.
>
> The cervical spine seems fine at the moment. It is conceivable that she may have acquired spinal cord injury which has slowly progressed, possibly syringomyelia, and that is why I have recommended MRI of the cervical spine. On balance I think it is unlikely that the prior motor vehicle accidents have been relevant.
>
> The fact is that her disability and handicap for work is the result of a mix of musculoskeletal injury, chronic pain with peripheral and central neuropathic mechanisms, impaired sleep and adjustment disorder with anxiety and depression ... I acknowledge, however, that some degree of exaggeration is probably usual in medicolegal contexts and is a fairly natural thing for a person to do in an effort to be believed and accepted and impress by the severity of disorder. In her case any such exaggeration or inappropriate report or response to examination was beneath my detection threshold".

33. Dr Champion was of the view that the Worker has a chronic pain disorder for a number of reasons which he links back to the original injury of the thumb. He did not diagnose the Worker as having CPRS Type 1 and did not accept in cross examination that the arthritis was contributing to the Worker's present symptoms.

34. Dr Olsen is a consultant physician who specialises in occupational and environmental medicine. He observed actual changes in the Worker's hands from "pink and beige" to "white and blanched" to whilst she was in his surgery. He also noted that the Worker's nails were "dyplastic" and "brittle" which he considered to be one of the symptoms of CPRS Type 1. Dr Olsen diagnosed the Worker as having CPRS Type 1. The doctor attached to his report the criteria that have been developed for the diagnosis of this condition and used that criteria in relation to the Worker. He found the Worker as having all of the symptoms typical of CPRS Type 1 however in his clinical observations the doctor did not observe sweatiness in the palms. The criteria set out were:

    - Continuing pain disproportionate to the initial event
    - Hypersensitive – Allodinya
    - Skin Colour changes
    - Brittle nails
    - Sweating in palms

35. Dr Olsen did not make any comment on the neck and shoulder pain because he didn't regard that to be part of the work injury or in any way related to the work injury to the thumb.

36. Ms Lucie Hardiman, occupational therapist gave evidence of her home assessment of the Worker's home duties. She explained her profession as assessing and assisting people with disabilities to maximise their functionality with day to day living. She attended the Worker's house on one occasion and observed the Worker in her home environment for a couple of hours. Ms Hardiman had the benefit of a functional assessment report by Konekt and relied on that report for her assessment, that report was not tendered in evidence by the Worker and was the subject of specific objection

by the Worker's counsel when the Employer's counsel attempted to refer the Worker to it.

37. It was Ms Hardiman's opinion that the Worker, while fiercely independent, required assistance in the home in the form of labour for heavier household duties and some modifications to the home such as tap handles to assist her in her day to day living.

38. The Employer submitted that Ms Hardiman's report and opinion should be totally disregarded because of her heavy reliance on a functional capacity assessment which was not before the Court. I accept that reliance does affect the weight I place upon Ms Hardiman's opinions however Ms Hardiman's report is also based on her own observations of the Worker's home environment and the symptoms the Worker reported experiencing to her.

39. The Court then heard from Dr Mah, treating hand surgeon, who had been involved in the Worker's care from late in 2005 to late 2006. He performed two surgeries on her right hand and provided several reports. Throughout that time he made observations regarding her symptoms. He produced a report on 4 May 2007 upon request by the Worker's solicitor which provides a good summary of his involvement with this Worker, the investigations he was referred to and his clinical observations of the Worker.

40. Dr Mah accepted that it is quite common for patients who have surgery in their dominant hand to have some pain in the other hand because of "overuse" of the other hand but that pain should settle in time. By "overuse" the doctor clarified that he meant using that opposite hand instead of the dominant hand for everyday tasks.

41. Dr Mah came to the conclusion that the Worker's reported levels of continued pain in both arms was not explainable by organic causes and suggested she be referred to a pain clinic for the management of that pain.

He gave the opinion that he thought the Worker was fit to return to work given appropriate duties.

42. Dr Jan Isherwood–Hicks, clinical psychologist, also gave evidence. She was the Worker's treating psychologist until the Employer ceased paying for the treatment. The Worker was referred to Dr Isherwood–Hicks in July 2006 at which time she presented as:

> " … acutely distressed, agitated, angry, anxious, tearful and depressed. Ms Newton advised she had just been informed by her doctor that she would never be able to return to CPA work involving lifting of heavy patients. Ms Newton was struggling with coming to terms with the reality of her permanent limitation, the impact on her life and the uncertainty of her employment future".

43. In her final report of 11 February 2008 Dr Isherwood–Hicks indicated that:

> "Ms Newton continues to present as extremely frustrated, angry, verbally explosive, anxious and depressed".

44. Her final conclusion was that the Worker continued to need "supportive psychological intervention" to address present symptoms and guard against further deterioration of symptoms and:

> … it is my opinion that once her case is finalised Ms Newton would again take charge of her health status and move on with her life".

45. The Employer then called evidence from Richard Woodside, an assistant principal at Stuart Park Primary, Ms Robin Morgan, experienced receptionist, and Ms Vicki Hulands, experienced Pharmacy assistant. Each of these lay witnesses gave evidence about the duties required of teacher's aides, reception work and retail assistant in a pharmacy as they have observed in their experience.

46. The Employer called Dr McLaren, psychiatrist, who saw the Worker on two different occasions after being referred to by the Worker's solicitors. Dr McLaren accepted that the Worker was displaying "features of a mild, reactive type of depression associated with a prominent anxiety state".

47. Dr McLaren was puzzled by the change in behaviour of the Worker from one appointment to the next. He describes her attitude and mood at the first meeting as “resentful, verging on hostile, from the moment she entered the office to the moment she left” and on the second meeting “ She was talkative and co-operative , with no signs of anxiety, hostility or suspicion”.

48. Dr McLaren was concerned that the Worker refused to give him a detailed history in relation to her interaction with her family and came to the conclusion that given that reluctance her relationship with her family was not ideal and could be a contributing factor to her present mental status. Dr McLaren does not accept that the Worker’s mental state has been brought about by the original injury to her thumb and concludes that the Worker was anxious prior to the injury. Dr McLaren is critical of Dr Walton’s report and his conclusions and the medication regime the Worker had been placed on by Dr Goodhand.

49. Dr Haynes was then called by the Employer, Dr Haynes is an occupational physician who saw the Worker once for a medico – legal assessment and who concluded that the Worker’s continued symptoms in her right hand are caused by osteoarthritis in her right thumb “caused or significantly aggravated by the incident on 14 April 2005”. Dr Haynes further concluded that the symptoms in the left forearm, wrist and hand were a result of “constitutional osteoarthritis” and that he does “... not believe that her left arm symptoms could be in any way linked to the right thumb injury of the 14 April 2005”.

50. Dr Haynes is of the opinion that considering the Worker’s capacity to work in relation to right thumb injury:

> “she is fit for a variety of duties where she can avoid forceful gripping and heavy lifting using her right hand. In my opinion she could undertake a variety of work as a sales assistant or sales representative or reception or clerical duties”.

51. Dr Thoo, occupational physician was called and adopted his reports and the transcript of his evidence at the previous hearing as his evidence in this hearing. Dr Thoo examined the Worker on 12 February 2008 upon referral by the Worker's solicitors. A transcript of Dr Thoo's evidence in the previous hearing was also tendered into evidence. The complaints the Worker related to Dr Thoo were set out on page 2 of his report as follows:

> "numbness and tingling affecting the tips of the third, fourth and fifth fingers of the right hand with pain involving the whole of the right thumb and wrist. She reports that her right hand often goes red and swells by the end of the day. The hand also gets hot and clammy for not particular reason.
>
> She continues to complain of numbness and tingling affecting the whole of the left hand and all the fingers, with occasional pain in the left wrist and thumb. She denied any other symptoms in her shoulders or neck".

52. On reported pain levels the Worker indicated to Dr Thoo that:

> "... she reports that she has a pain level of 5/10 in the right hand whilst she is on medication and 20/10 with no medication . The left pain in rated as 5/10 and is not improved with medication, with her left hand symptoms being largely numbness and tingling".

53. In previous cross examination Dr Thoo agreed that if the Worker had reported to him neck and shoulder pain as well as the above symptoms he would expect that there was neck injury at the root of the symptoms. Dr Thoo was examined on his findings regarding the results of the grip strength tests he performed on the Worker. The doctor was asked to explain the consistency of the results over a range of positions on the Jagmar Dynometer, to which he answered:

> "There can be a number of reasons. I mean, firstly, it could represent true maximum strength. It could also be due to self limitation due to pain, fear of injury and lastly just plain sort of malingering or fraudulent – you know (inaudible) how can I put it? They're simply not trying".

54. Dr Thoo could not explain the Worker's reported symptoms by physiological causes and suggested that there is a "functional component" to her symptoms for which he would defer to a psychiatrist or psychologist.

55. The medical investigations of the Worker's right and left arm were:

    1. Radiological investigation of the right hand by Dr Kristen Gormley – 15 April 2005

    2. Radiological investigation of the right thumb by Dr John Reece – 20 April 2005

    3. MRI of right thumb by Dr John Sykes - 7 July 2005

    4. X-ray of the right thumb ultrasound by Dr David Croser - 30 September 2005

    5. Bone scan of both hands by Dr Chew - 6 October 2005

    6. Nerve conduction study of 10 February 2006

    7. MRI of right thumb Dr David Croser - 15 June 2006

    8. Electrophysiology report by Dr Lee - 1 August 2007

56. These investigations were considered by the doctors as they were produced and it is agreed that the there was evidence of osteoarthritis in both the right and left hand and shoulder & bone scans were normal and did not show unusual blood flow nor did the nerve conduction study.

Validity of Notice

57. Before this Court considers whether the evidence supports the Worker's claim for continuing weekly benefits based on her continuing incapacity, there are several legal issues raised by the Worker's Statement of Claim which first must be decided. The validity of the Notice of Intention of Cessation of Benefits served on 17 May 2007 has been challenged by the

Worker. The argument is that the Notice was not valid because it did not attach a medical certificate nor was it expressed in terms that provided sufficient detail to enable the Worker to understand why the amount of compensation was being ceased.

58. It is clear that there was no medical certificate attached to the Notice and it is trite law that it is mandatory that a certificate be attached (see *Ansett Australia v Niewmans* 9 NTLR 125) however the Employer argues that in the circumstances of this case the medical certificate is not required.

59. The Employer submits that the Notice was not ceasing payments on the basis that the Worker was "had ceased to be incapacitated for work", that is pursuant to section 69(3) of the *Work Health Act*.

60. The Employer bases its argument in the definition of "incapacity" in section 3 of the Act. That is incapacity is defined as:

> "an inability or limited ability to undertake paid work because of an injury"

61. It is submitted that the Notice was not claiming that the Worker had ceased to be unable or have limited ability to undertake paid work because of an injury. The Employer accepts that the Worker continues to have a limited ability to undertake paid work because of her injury however that injury does not stop her from undertaking work which would nett her an income equal to or more than her Normal Weekly Earnings. That is even though the Worker has some continued incapacity to work from the "injury" that incapacity does not preclude her from undertaking all paid work.

62. It is instructive to consider the actual terms of the Notice as served which were as follows:

> "(i) You suffered a work related injury to your right thumb on or about 14 April 2005;

(ii) Your indexed normal weekly earnings for 2007 is $516.90 gross per week;

(iii) You currently have an earning capacity based on your fitness to carry out at least 37 hours of work with an alternative employer as a teacher's aid. Your earning capacity from such employment is $600.00 per week;

(iv) You have been certified by Dr Philip Haynes as fit to undertake the work duties required of a teacher's aid;

(v) You have been certified by Dr Goodhand as fit to undertake the duties with an alternative employer in 37 hours per week;

(vi) You are fit to work as a teacher's aid for at least 37 hours per week and have an earning capacity of at least $600.00 per week;

(vii) Pursuant to section 65(2) (b) (ii) of the Work Health Act (NT) your weekly compensation benefits is reduced to 75% of the difference between your indexed normal weekly earnings and your earning capacity namely nil".

In essence the Employer's submission is that where the Worker's "limited capacity to earn" does not translate into a loss of earning capacity then a medical certificate is not required when using section 69(3) to cease benefits. Followed to its natural conclusion this argument would mean that if the Employer has <u>any</u> information, (medical or otherwise eg discovery the worker has qualifications that the Employer was not previously aware of), which could increase the Worker's earning capacity to more than the Worker's normal weekly earnings, then a medical certificate is not necessary. This reasoning is fundamentally flawed. In the present case, the Worker has had benefits paid to her on the basis of Dr Goodhand's certification and there is not suggestion that her medical condition has changed yet she has received a Notice of Termination to say her capacity to earn is more than her normal weekly earnings. If a worker has been certified as unfit for work by a medical practitioner, then any contrary view based on a medical opinion must be supported by the opinion and certification of relevant medical practitioners and properly put before the Worker. If the

certification is not available, then it would be untenable to allow the Employer to unilaterally cease a worker's payments on the basis of a capacity to work when the worker has been told by their doctors that they are unfit for work.

63. In the present case, the Employer relies on the "certification" by Doctors Haynes and Goodhand of the worker's ability to return to work and it is clear from the authorities that because the process of cessation of benefits pursuant to section 69 is unilateral in nature, then any such certification must be supported by the appropriate certificate. The reasoning in *Collins Radio Construction Inc v Day* [1997]140 FLR 347 applies to this situation even where it is not claimed by the Employer that the Worker has ceased to be "incapacitated" for work due to her work injury. The whole purpose of section 69 is to ensure that any unilateral reduction or cancellation of benefits under section 69 is on proper grounds and understood by the Worker. What worker could be expected to accept and understand a Notice of Cancellation of Benefits on that basis that the doctor who continues to certify her unfit for work has "certified" her fit for duties with "an alternative employer 37 hours per week".

64. It is just as important in this situation that the Worker is made aware that there is some basis for the cancellation not just the Employer's decision. A certification or report by the doctor, in the present case Dr Goodhand, would show the Worker that Dr Goodhand had distinguished between incapacity to return to work in the same job the worker had before the injury and other occupations.

65. Clearly I do not accept that there is no need for a medical certificate in this case and the Employer's argument pursuant to section 69(3) must fail, the Notice is defective and therefore on that ground the Worker would be entitled to benefits from the date of cessation until today, had the pleadings been limited to that issue.

66. In relation to the submission by the Worker that the Notice did not comply with section 69(4), that is it was not in terms "in sufficient detail to enable the Worker to understand why the amount of compensation was being reduced or cancelled", it is important to look to the standard of the test. The Worker's evidence, given over the objection of the Employer's counsel, was that she did not understand the Notice. The Employer's submission is that the test must be an objective test otherwise an Employer would have to be aware of the Worker's educational levels, intelligence, language skills and apply that knowledge to the drafting of the Notice and even if the Employer had access to that information there could never be any certainty of the Worker's understanding.

67. The Worker quoted *Ansett v Niewmans* (supra) as authority for the proposition that the Notice must be in terms that the Worker can subjectively understand the reasons behind the cessation of benefits. That submission was unhelpful as it is clear from the reading of that authority the Court did not even consider that issue. While the Court in that case did consider s 69 (4), it did not turn its mind to the standard of the test and on the facts of that case did not need to.

68. I have not been referred to any authorities specifically on this point however it would be extremely onerous upon the Employer if they were required to ensure that the details in the Notice were in the form that the particular Worker in all his or her circumstances would subjectively understand. The effectiveness of the process would be brought into question because all the Worker would have to say is that he or she did not understand the Notice and the validity of the Notice would be questioned whether or not it was a reasonable claim.

69. It is my view that the test must be an objective test with a subjective element. That is the Employer is required to provide detail to make the

Notice understandable for the ordinary person such that the particular worker should have understood the Notice.

70. Whatever test is applied, the terms of the Notice presently considered are, in my view, confusing for the worker. Particularly the indication that Dr Goodhand had certified her as fit to undertake duties with an alternative employer for 37 hour week. This worker has received medical certificates from her GP Dr Goodhand certifying as unfit for work and yet she received a Notice saying the opposite without supporting medical certificate. It is all very well for the Employer to rely on legal interpretation of the word" incapacity" however it is that reliance which must ring warning bells in relation to the Worker's ability to understand the notice.

71. The conflict between the medical certificates certifying the worker as "totally unfit for work" and the Notice saying she is certified fit for alternative work by the same doctor would no doubt cause confusion, in an objective sense, if the Worker was not provided with further explanation.

72. Given the above it is my view that the Notice also fails to comply with section 69(4) and as such is invalid.

73. The claim that the Notice did not comply with section 69(1) is not made out as it is clear that all of the requirements were fulfilled.

74. While the Notice of Termination of Benefits is invalid and on that basis the Worker would be entitled to the reinstatement of benefits, the Court must still consider the Worker's further claim in relation to her consequential injuries and the Employer's counter-claim.

Chronology of injury and medical attendances

75. It is useful to set out the chronology of the Worker's injury and medical attendances to better understand the progression of the Worker's symptoms. The Worker herself could not give evidence of how her symptoms had

developed and did not remember what she told the different doctors but did reluctantly accept in cross examination that what the doctors' recorded as her reported symptoms must have been what she told them.

Date	Incident/attendance	Results/Symptoms
14.4.05	Injury to right hand at work	Felt thumb had come away and was just "hanging". Pain in wrist and thumb and burning sensation
15.4.05	X-rays on right hand	Showed erosive osteoarthritis in 2nd,3rd,4th,& 5th fingers and mild degenerative changes at the 1st metacarpal joint
7.7.05	MRI right thumb	No convincing tear or retraction of the ulnar collateral ligament at the metacarpal joint
30.9.05	Ultrasound on wrist	Showed features consistent with osteoarthritis at 1st metacarpal joint and no disorder of the ulnar collateral ligament of metacarpalpophlangeal joint
30.9.05	Dr Flavell	Burning sensation in right thumb, shooting pain travelling up to neck and shoulders, right palm sweating and paler than left
6.10.05	Bone Scan	No alteration of blood flow. Some signs consistent with arthritis in scapho-trapezium-trapezoid joint in right hand and in joints of 2nd an 5th digits. In left hand no abnormal hyperaemia by evidence of arthritis in 2nd and 5th digits. Comments on that report was that no evidnec o reflex sympathetic

		dystrophy/CPRS 1
15.11.05	Dr Mah	Noted tenderness over carpametacarpal joint and laxity in ulnar collateral ligament. Grip strength was tested and was 9kg on right hand and 28kg on left hand
7.12.05	Dr Mah	Conducted surgery to repair ligament. Worker suggested this was due to overuse
9.2.06 14.2.06	Dr Mah review	Post operatively grip strength tested 6kg on right and 16kg on the left. Reported pain in left shoulder radiating down the arm and numbness along ulnar three digits. Suggested left shoulder nerve impingement. Referred for further xrays and nerve conduction test
10.2.06	Nerve conduction test	Little evidence to support the worker was suffering from carpal tunnel syndrome or ulnar nerve injury. Fairly normal median and ulnar nerve function in left hand
21.7.06	Dr Mah	Carpal tunnel release on right ulnar nerve
27.7.06, 2.8.06 9.8.06	Dr Isherwood – Hicks	Acutely distressed, agitated, angry, anxious, tearful and distressed. Adjustment issues to being told by doctor that she couldn't return to previous work because of heavy lifting. Still having problems with left shoulder
6.10.06	Dr Mah review	Sensation in right hand improved, but still weak. Continued pain in whole of left upper limb with pins and needles in the left ulnar 3

		digits. Grip strength 6kg on right and 8kg on left
16.10.06	Total Health and Rehab, Beth Taylor Physiotherapist	Increasing problems with left hand (support helps). Grip Strength 6kg right and 7kg left
10.11.06	Functional assessment by Konekt	not provided to court
23.7.07	Dr Haynes	Ongoing pain at base of right thumb, generalised pain base of left thumb and pain extending to left wrist and forearm. No pain in left elbow or shoulder. Tenderness in the right elbow
17.5.07	Form 5 served	
18.7.07 & 13.9.07	Dr. McLaren	Lethargy, sleeplessness, trouble thinking clearly, miserable most of the time, agitation most of the day. Pins and needles and dull throbbing ache around base of right thumb and wrist intensity depends on what she is doing, hand sometimes bright red and others pale and sweaty. Hand is swollen and fatter. Left hand exactly the same as right with occasional shooting pain up the arm and pain and discomfort in left shoulder
31.8.07	Dr Mah review	Constant aching and throbbing pain in whole of right thumb with pain in right wrist with activity. Pins and needles in right hand involving the ulnar three digits and numbness in right elbow. Left hand constant pins and needles in whole of left hand radiating from wrist to forearm. No pain in shoulder

11.1.08	Lucie Hardiman	Constant pain in right wrist and thumb, right shoulder pain, constant pins and needles in little, ring and middle fingers of right hand. Left wrist, elbow, shoulder and neck pain. Constant pins and needles in all fingers of the left hand. Decreased grip strength in both the right and left hands
12.2.08	Dr Thoo	In right hand numbness and tingling in tips of third fourth and fifth fingers. Pain of whole right thumb and wrist. Right hand often goes red and swells and hot and clammy, and lack of strength. Numbness and pain in right elbow. In left hand numbness and tingling in whole of left hand and all fingers with occasional pain in the left wrist and thumb. No shoulder pain. Pain in right hand rated 5/10 on medication and 20/10 without. Left hand rated as 5/10 with or without medication
25.3.08	Functional capacity assessment – Kassie Heath	Right hand symptoms – constant pain in right thumb, constant pins and needles three ulnar fingers, intermittent numbness in right elbow. Intermittent shoulder pain when carrying. Left hand symptoms – intermittent thumb pain worsening over time, constant pins and needles all fingertips (including thumb) but not radiating down the digits. Headaches after driving and when stressed and anxious.
27.3.08	Dr Olsen	Pain in both hands, hands become sweaty and clammy. Veins become more prominent

		by the end of the day palms become blotchy and read and then burning pain and sweating. Hands also then become white and cold primarily on the dorsal side
31.3.08	Dr Walton	Widespread pain involving shoulders and both arms. Pain varying between dull ache and more intense throbbing pain. Base of thumb particularly painful, and pins and needles in right 3rd 4th and 5th fingers and tenderness on the elbow. In the left hand there pain at the base of the thumb and the fingers are prone to pins and needles. Worker also reported headaches Psychiatrically the worker reported depressed mood ongoing anxiety and easily becoming angry and tearful. She also reports sleeplessness disturbed sleep, lack of concentration and forgetfulness
28.5.08	Dr Champion	Intermittently tearful, evidently depressed and exhibited some anger. Stated her emotional responses are more severe when pain is increased then she gets upset, cries and even vomits and has worse headaches Right hand – dull throbbing pain in right thumb and dull throbbing pain in right wrist. Pins and needles in middle, ring and little fingers Left hand – dull throbbing pain in left thumb and wrist with intense pins and needles

involving all five digits

Continuing disability regarding the right hand

76. Clearly there is no dispute regarding the original work injury to the Worker's right hand or the need for the operations performed by Dr Mah in 2005. The Worker's case is that even after the operations whilst she noticed some improvement, her thumb didn't feel like it was falling off, she has continued to have difficulties with her right hand. She has always complained of pain after using her right hand and continuing weakness in that hand which she says is evidenced by the fact that she had a reduced grip strength in that hand.

77. Her present complaints of her right hand is that she is in constant pain, 5 out of 10 while on medication and 20 out of 10 when not on medication (see page 2 of Dr Thoo's report of 14 February 2008). She says she can do day to day things with her right hand such as writing (in an altered grip) and most household duties (at a slower rate than before the injury) and driving in a modified vehicle. The Worker says that any sort of repetitive activity with her right hand will cause her great pain.

78. After a functional capacity evaluation undertaken on 25 March 2008 by Moving with Industry, the Worker:

> "Unsolicited, Ms Newton then phoned a second time that day, at 5.06pm, to report that her pains were now "excruciating", affecting her "whole body" and rated at a 10/10 intensity".

79. This was clarified with Ms Newton and she accepted the pain in her thumb was her usual pain just at a higher intensity than what she usually experienced.

80. Before the operation by Dr Mah in late 2005 the Worker complained to Dr Flavell of:

> "a burning sensation in her right thumb" and

"a shooting pain which travels up her arm to her neck and shoulder"

81. The Worker was then operated on by Dr Mah to repair the ligament damage to the right thumb and it was noted before the operation that the worker had 9kg grip strength on the right hand and 28kg on the left.

82. Once the operation had been performed the Worker was reviewed by Dr Mah who noted "much better range of motion and function with grip strength measuring 6kg on the right and 16kg on the left". The doctor's report 14 February 2006 expressed his opinion that the Worker was "noted to be progressing well". On the final page of that report he suggested:

> "(2) She could start a return to work programme in the next week or so
>
> (3) Avoiding overhead and repetitive heavy lifting, pulling and pushing with her right hand for another 4 weeks or so
>
> (4) Provided the duties are appropriate, I see no reason to restrict her hours".

83. Dr Mah had been referred to the letter from Ms Clee of KONEKT of 27 October 2005 (E4) which included a suggested return to work program and by his answers to the questions put to him (by QBE) as set out above was of the opinion that given the appropriate duties the Worker could participate in the return to work program.

84. In his report of 29 November 2006 Dr Mah referred to a Functional Assessment report and Vocational Assessment report by KONEKT (which were not tendered as evidence) and agreed that the suggested duties of retail and small business management, welfare worker and teacher's aide would be reasonable options to present to the Worker.

85. Dr Mah accepted that the Worker's partial capacity was due to "both organic and non – organic illness". He also states that:

> "prognosis is generally poor given the lack of progress and persistent symptoms and development of symptoms in the opposite limb and non organic illness".

86. Having referred to Dr Haynes report Dr Mah defers to him as an occupational physician and suggests the Worker's capacity to work is as Dr Haynes state in answer to question 10 "In my opinion she has the capacity to undertake some work as a sales consultant or as a welfare worker or teacher's aide".

87. The Employer submits that the Court should accept Dr Mah's opinion that the Worker should have been physically able to undertake alternative duties as a continence nurse full time and the duties of retail and small business management, welfare worker and teacher's aide. The Employer also submits I should accept Dr Mah's deference to Dr Haynes as an occupational physician in particular because Dr Mah as her treating surgeon has assessed the Worker's capabilities in light of her physical restrictions.

88. It is clear from Dr Mah's reports that he was of the opinion that the Worker should have been able to get better function back into her right hand subsequent to the surgery and that he has no explanation for why she continues to have difficulties with the right hand except for "non–organic illness".

89. It is clear from earlier medical reports and investigations that there was no physiological explanation for the continued symptoms in the right hand. The suggestion of exaggeration of symptoms (Moving with Industry report), "non–organic illness" (Dr Mah) or "functional component" (Dr Olsen) became clear from those reports. The suggestion by Dr Mah that the Worker be referred to a pain clinic was an indication that Dr Mah could not explain the continuing difficulties that the Worker was having with her right arm.

90. Several medical professionals tested that functionality of the right hand over the years and one of the tests used was the grip strength test measured on the

Jagmar Dynometer. The results recorded by Dr Mah on grip strength on the right hand showed a limited grip strength before the surgery and a slight improvement in that strength after surgeries. Other tests on the right hand since Dr Mah's surgeries show no real improvement in grip strength of the right hand. Dr Mah accepted in cross examination that a person's grip strength may be low because they are not trying as hard as they could either because they are fearful of the pain it may cause or they are exaggerating their symptoms.

91. There were some objective tests performed on the Worker such as bone scans, x-rays and nerve conductions tests, all of which showed the Worker to have normal responses etc except that she had osteoarthritis showing up in both hands and shoulders.

92. The explanations proffered by the various medical practitioners as to the Worker's continuing difficulties with her right hand vary from, possible issues with the neck (Dr Thoo), complex regional pain syndrome (Doctors Olsen and Champion), degenerative changes in the hand(Dr Goodhand), and significant arthritic changes in the thumb given the original injury.

93. All of the diagnoses by the different doctors rely upon the Worker's history of her symptoms, the objective tests such as the nerve conduction studies, and clinical observations, eg how the Worker responded to touch and grip strength tests as well as the physical appearance of her hands. Of course it is the normal course of a medical examination for a doctor to enquire of the patient what symptoms they are suffering and to conduct clinical tests. It is also a normal state of affairs for the doctor to enquire about other possible symptoms if they have a diagnosis in mind and want to ascertain if the patient has additional symptoms to support that diagnosis.

94. The Employer submitted that it is because the doctors may have asked leading questions about the Worker's symptoms then that may have put the idea into the Worker's head that she should display those symptoms to get a

more favourable diagnoses. This is just supposition and there is no evidence to support this theory.

95. The clinical observations of the Worker's hands are set out in the summary of evidence above and it is clear from that evidence that the Worker's symptoms changed over time and developed in her left arm and hand over time.

96. It is clear on the evidence however that the Worker is still having difficulties with the right hand whether the diagnosis is one of CPRS Type 1 or arthritis and therefore her capacity to earn must take into account that disability. All of the doctors accept that the injury she sustained in the right thumb could have resulted in either CPRS Type 1 or arthritic changes which could explain the continuing symptoms.

97. While it is suggested by all of the doctors that all continuing symptoms in the right hand can not be explained by the physical analysis of the Worker's hand, any psychosocialogical factors which are influencing the Worker's behaviour may be leading to an exaggeration of her symptoms of her right hand, not necessarily a total feigning of those symptoms.

98. Even accepting the Worker may have continuing symptoms in her right hand any incapacity of the Worker to earn in relation to her right handed symptoms must be considered in light of her alleged symptoms in her left arm.

Consequential injuries

99. The Worker claims that as a consequence of the original work injury to her right thumb she has suffered a consequential injury to her left hand arm and shoulder and further psychiatric or psychological condition as a result of her injury to her right hand.

100. In relation to the left arm symptoms the Employer denies that the Worker is suffering those symptoms and/or that those symptoms are consequential to the original injury to the right hand. The Employer also argues that no claim form has been completed in relation to this alleged injury as is required by the *Work Health Act*. In relation to the psychiatric or psychological condition the Employer denies the condition has developed as a consequence of the injury to her right thumb, notice of the "injury" was not given as soon as practicable and the Worker has not completed a claim form in relation to that injury.

101. The Worker submits that symptoms relating to the left arm and the psychiatric or psychological condition are consequential upon the original injury not a new injury under the Act and therefore a claim form is not required. The Worker also submits that the Employer received notice of these consequential injuries as they occurred and acted on that notice. The Employer has referred the Worker to a number of medical practitioners to establish the cause of the left arm symptoms and in relation to the psychological claim paid for treatment with Dr Isherwood–Hicks for a period of time.

102. It is trite law that if these alleged symptoms in the left arm and the psychological condition are sequelae to the original right hand injury then they are not new injuries under the Act and a claim form is not necessary.

103. It is also of note that on 12 December 2006 the Worker's solicitors sent an email to the Employer indicating some matters of "contest" between the parties and those matters were subject of a Certificate of Mediation issued on 26 February 2007. It is not accepted by the Employer that the email of 12 December 2006 constituted a proper referral of those matters in contest, however it is accepted that a Certificate of Mediation was issued. I note that I have received no evidence regarding the issue of that Certificate of Mediation, nor the contents of that certificate. I am not informed as to the

outcome of that mediation or if a mediation conference actually took place. I can only assume that as the matter is now before the Court, the mediation process was unsuccessful. I can reach no conclusion whether the Employer participated in the mediation conference. If I had that information I would have been able to take notice of that participation as an acceptance that there were some contested issues between the parties.

104. Prima facie the issue of the certificate of mediation on 26 February 2007 puts these issues properly before the Court and without evidence to the contrary, I accept that these matters are properly before the Court. The Employer has not called evidence to the contrary.

105. To include the left arm and psychological symptoms in the assessment of the Worker's capacity to earn, the Court must accept on the balance of probabilities that those symptoms are consequential to the original injury to the Worker's right hand.

106. Given that these issues are before the Court on an application by the Worker, outside of the "appeal" regarding Notice of Cessation of Benefits under section 69 (see paragraph 17 and 19 of amended Statement of Claim), then it is the Worker's evidential burden to prove that these two "consequential injuries" are just that, consequential upon the original injury. The Employer has never accepted responsibility for the left hand difficulties or the psychological symptoms in the past. The Employer's non acceptance of those injuries is confirmed in the Worker's Amended Statement of Claim paragraph 10.

107. The Worker's evidence is that she started to feel her left hand "was getting weak from using it a lot" after her first surgery by Dr Mah on 7 December 2005.

108. The medical evidence regarding the left hand symptoms was subject to close scrutiny by the Employer. First complaint of any left arm pain was to Dr Flavell in September of 2005, on page 2 of his report he states that:

> "Given she is now using her left arm much more for activities she is experiencing pain throughout her left arm. This is worse at the end of the day".

109. Dr Flavell's observations regarding the "difficulties" in the Worker's left arm is reflected in his report of 25 October 2005 in his answer to the question as to what treatment was required:

> "Caution is going to be required to ensure that she does not put too much load on her non dominant arm and thus develop increasing difficulties with it".

110. In cross examination Dr Flavell couldn't remember whether he had asked the Worker if she had problems with her left arm or if she volunteered the information, but his evidence is that if the Worker had not volunteered the information, then he would have asked. The doctor also conceded in cross examination that he would not expect using the hand for normal day to day activities would cause an overuse issue, although some activities may bring it on for example, repetitive cleaning.

111. The letter of referral to Dr Mah by QBE date 8 November 2005 mentions the left arm symptoms in reference to a return to work program:

> "the limiting factor to date in increasing Miss Newton's activities at work has been reported pain in the right thumb and progressing into both upper limbs by the end of the day".

112. Dr Mah also agreed that generally there is a danger of "overuse" of an opposite hand if the dominant hand has been operated upon however he would expect that to settle once the other hand has recovered. He accepted that the suggestion of "overuse" was made by the Worker and not him and that it was more likely with repetitive tasks. Nevertheless he accepts that the condition could develop simply because there is more use of the non

dominant hand. The puzzling thing about the report of left arm symptoms to Dr Mah is that they change over time. In his reports of 10 and 14 February 2006 the left arm symptoms are:

> "pain in the left shoulder which radiates down the arm and forearm and also some numbness along the ulnar three digits"

113. Which the doctor diagnosed as "mild left shoulder impingement and left ulnar nerve neuritis".

114. Then in Dr Mah's reports of 12 October 2006, 29 November 2006 and 4 May 2007 the left arm symptoms are described as:

> "whole left upper limb pain now with pins and needles involving the left ulnar 3 digits"

115. The next report of 6 August 2007 describe the symptoms as:

> "Constant pins and needles in her left hand, whole left hand radiating from the hand/wrist to the forearm. Her left shoulder is fairly asymptomatic at present".

116. Dr Goodhand notes left arm pain for the first time in the Work Health Medical certificates in the certificate dated 18 December 2006 and up to 3 July 2008 he endorses those certificates as "L arm and hand overuse".

117. In his report of 16 April 2007 Dr Goodhand opined that because the Worker was unable to use her right hand for a length of time "she sustained an overuse injury to her left arm and hand – which was also already incapacitated (to a lesser degree) by the degenerative process in her left shoulder – while attempting the graded return to work. Hence overtime this produced a chronic strain injury in the left arm with the resultant pain Mrs Newton describes". In cross examination on those comments Dr Goodhand accepted that upon receiving complaint by Ms Newton of the left arm pain, he would have asked her about that pain and discussed with her the possible causes of that pain. He confirmed that the Worker first mentioned pain in the left arm on 2 March 2006.

118. Dr Goodhand also accepted that the Worker's pain in her left hand could not be explained by physiology and that there must be a psychological component to the Worker's symptoms.

119. In her report to Dr Mah of 28 September 2006, Beth Taylor from Total Health and Rehab states that:

> "Ms Newton mentioned tingling of [L] hand recently"

120. On 16 October 2006 Ms Taylor also mentioned that:

> "Cheryl is having increasing problems with her [L] hand. This has been helped by the use of a neoprene support".

121. Then in a document dated 11 July 2007 to QBE Ms Taylor requests funding for continued treatment naming the "Injury" as:

> "R thumb ligament reconstruction, R median ulnar nerve releases, bilateral shoulder pain, L arm pain, headaches"

122. Further comment made in that document by Ms Taylor was:

> "On discharge, was free from headaches, neck and shoulder pain. Pain in R & L hands and forearms remains"

123. Although Ms Taylor's comments are not an indication of what was causing the left arm symptoms, it is clear from those comments that Ms Newton was complaining of "pain in her left arm and shoulders" between September 2006 and July 2007.

124. Ms Newton then saw Dr Thoo on 12 February 2008. Dr Thoo is an occupational physician and the symptoms reported to him were:

> "She continues to complain of numbness and tingling affecting the whole of the left hand and all the fingers with occasional pain in the left wrist and thumb. She denied any other symptoms in her shoulders or neck …. The left hand pain is rated as a 5/10 and is not improved with medication, with her left hand symptoms being largely numbness and tingling".

125. So at the time she saw Dr Thoo, the Worker was having no further problems with her shoulders and neck but continuing to have difficulties with the left hand which was not helped by medication. There is no information as to what medication was used at the time.

126. It is not disputed that the Worker had been in two motor vehicle accidents about 20 – 25 years ago resulting in whiplash type injuries, one of which required her to have extensive physiotherapy. The Worker claims that since recovering from those accidents she has not had any further issues with her neck until after the surgery in 2005 when she was required to use her left arm while her right was disabled. After the first complaint regarding her left hand, those symptoms got progressively worse until on the Jagmar grip strength test administered by Dr Thoo showed that the hands were equal in weakness, at 4kg on both hands (see page 3 of Dr Thoo's report).

127. Dr Haynes was asked to assess the symptoms in the left arm, wrist and hand and came to the conclusion that the symptoms were likely to be caused by the "constitutional osteoarthritis" (see page 5 of his report 2 March 2007). He found that the Worker was exaggerating her symptoms because of the level of pain she reported after the functional capacity assessment eg 20/10. He accepted that there was a condition CRPS Type 1 however was of the view that people with genuine cases of CRPS Type 1 are not prone to such exaggeration. Of course his opinion is completely opposite to that of Dr Olsen who diagnosed CRPS Type 1 in both limbs and emphatically denied any influence of arthritis on the Worker's pain levels.

128. Dr Olsen observed some changes in the colouring of the Worker's hands at the time of his examination of her as described in his report as:

> "At the beginning of the examination there was no abnormality of colour of her hands. During the medical examination however red mottling began to appear on the palms of both hands. At one point in the examination the dorsum aspect of both hands became white and

blanched. Within a few minutes the whiteness disappeared and the colour returned to normal".

129. Dr Olsen diagnosed the Worker as having bilateral CPRS Type 1 but conceded that the Worker's reported pain levels and all of her symptoms could not be explained by that condition. He did not accept that the Worker was exaggerating but suggested that there may be "psychosocial factors" which contributed to her unusual presentation.

130. Dr Champion, a recognised specialist in pain medicine, was more conservative in his diagnosis finding the Worker's left arm symptoms perplexing and while diagnosing the Worker to have a chronic pain syndrome, he was not prepared to diagnose bilateral CPRS Type 1.

131. The Worker claims that she has a continuing disability to work because of the combination of her right and left arm symptoms.

132. All of the clinical tests undertaken by the doctors and in the functional capacity assessment by Moving Industry, all relied on the Worker's responses to questions and tests. The results were varied and puzzling.

133. One of the tests relied upon by doctors and the functional capacity assessor was the grip strength test. This is a test which is conducted by the patient being asked to squeeze on a calibrated instrument to register the strength in that persons hands. Since 2005 the Worker has had several of these tests which has shown a steady decline in the right hand strength from 16 kilos to 4 kilos and a dramatic decline in the left hand from 28 kilos (considered normal strength) to 4 kilos. The results of those tests rely on the patients report back to the assessor as to when they cannot apply any more pressure. The response to this test is purely subjective and both Dr Mah and Dr Haynes suggested that the Worker's reported decrease in strength of the left hand was not explainable.

134. Ms Heath, the physiotherapist who performed the functional assessment on the Worker also noted a disparity between the reported grip strength and the bilateral lifting capacity. Ms Heath stated that:

> "… it is normal that an individual's grip strength (in kg force) is greater than their bilateral lifting capacity (in kg). This was not the case for Ms Newton. Also her left hand grip graph was more inconsistent than that of the right. Yet she did not report any left hand pain at the early stage of testing".

135. There was also some inconsistency in the reported responses to Dr Champion's and Dr Olsen's test for light touch on the affected areas. One of the tests for a diagnosis of CRPS Type 1 is the response to light touch on the affected area. When Dr Champion tested the Worker she stated that she could not feel the touch as much as on an unaffected area, yet when Dr Olsen applied the same test and she indicated that the feeling was unpleasant.

136. Dr Olsen accepted in cross examination that he could not be sure whether the Worker was exaggerating her symptoms and that there was no method to differentiate between wilful or subconscious exaggeration. He also said in cross examination that there was no way of telling whether there was fabrication or chronic pain syndrome.

137. Dr Champion accepted in his report that if there was exaggeration it was below his level of detection and in particular that he did not detect any exaggeration on the Worker's behalf. Dr Champion also agreed in cross examination that if there was such reduced grip strength then there would be correlating decrease in bilateral lifting strength. He agreed that the Worker's case was "a difficult case to interpret" because of some unusual responses. He was adamant however of his diagnosis of a chronic pain syndrome because when he did the deep pressure test on the right thumb, the Worker reported pain and that response married with the decreased sensitivity to the light touch, indicated to him that the Worker was <u>not</u> feigning. This analysis

is brought into doubt if you accept the Worker's response to the same light touch test when performed by Dr Olsen as a reported unpleasant abnormal feeling.

138. In cross examination Dr Champion also emphatically denied that the Worker's arthritis was in anyway contributing to her present symptoms however that does seem at odds with his observations recorded on page 5 of his report:

> "At the right 1st carpometacarpal joint there was pain on active and passive movements and tenderness to palpation, consistent with reasonably aggressive osteoarthritis"
>
> And on page 14:
>
> "There were indications also of aggravation with resultant persistent pain related disability of the osteoarthritic right first carpometacarpal joint. Very likely there has been a symptomatic aggravation of the previously asymptomatic osteoarthritic joint between scaphoid trapezium and trapezoid (STT) joint".

139. One of the other symptoms of the CRPS Type 1 was abnormal sweating and skin temperature changes and neither Dr Olsen or Champion observed this occurring. This was one of the reasons that Dr Champion did not diagnose CRPS Type 1, rather a chronic pain syndrome in general even though this symptom was reported regarding the right hand to Dr Flavell in 2005.

140. The other reason that Dr Champion was not prepared to diagnose CRPS Type 1 is that:

> "Furthermore, the radionuclide bone scan did not support that interpretation."

141. Yet in cross examination when Dr Champion was asked if a normal bone scan was an indication that CPRS Type 1 did not exist in the patient, he said that was not necessarily the case.

142. It is clear that the Worker had been referred to Drs Olsen and Champion because her pain levels and symptoms could not be explained for by any orthopaedic or neurological condition. Her collection of symptoms were changing and developing and because of that, did not fit with any diagnosis.

143. It is also clear from the medical evidence of the experts in pain medicine that CRPS Type 1 is a recognised condition which is usually only diagnosed when all other diagnoses fail and that the occurrence of the condition manifesting in the opposite uninjured limb is rare. It is of note that Dr Champion, recognised expert in the field of pain medicine, stated that CPRS Type 1 and 2 are the subject of his next research project that suggests that these conditions are still a subject of research.

144. Even Dr Olsen suggests that the Worker should be psychologically assessed because her responses to some tests are still not explainable by a diagnosis of CRPS Type 1.

145. The Worker has been treated by Dr Jan Isherwood-Hicks and a report from Dr Isherwood–Hicks was produced to the Court. This report did not address the possibility of the Worker exaggerating her symptoms and it is clear that Dr Isherwood–Hicks also accepted that the Worker had physical limitations as describes and concentrated on addressing the anxiety and depression which arose from the loss of earning capacity. Ms Isherwood–Hicks diagnoses the Worker as having anxiety, depression and adjustment difficulties as to her loss of ability to work as a carer. Ms Isherwood–Hicks also suggests that once the litigation around the worker's claim is resolved, she is more likely to be able to "move on". This analysis of the Worker's emotional wellbeing is an indication that once her Work Health litigation is resolved, the Worker would more likely be able to adjust better to her loss of ability to work as a carer.

146. The Worker was also referred to Drs Walton and McLaren for psychiatric assessment. Both of those doctors agreed that the worker was showing signs

of anxiety and depression with Dr Walton going further in his opinion that she was also suffering a "chronic adjustment disorder".

147. Dr Walton is criticised as to his lack of explanation in his report about how he came to his conclusion and I agree that his report requires the reader to accept his diagnosis without real explanation as to how he has come to that conclusion. He does not set out his clinical observations of the Worker which support this opinion or how he comes to the conclusion that the symptoms described by the Worker are causally linked to her original work injury. He assumes that her psychiatric symptoms must be because of her chronic pain without discussing what situations bring about an increase in those symptoms (such as her anxiety). Without those explanations, Dr Walton's report can be given little weight. He even states that it is "hardly a matter for psychiatric expertise" that a person with chronic pain will either develop a psychiatric condition which is caused by the constant pain or a psychiatric condition which amplifies the pain". Dr Walton then comes to the conclusion that in this worker's case, he is of the opinion that the psychiatric condition is caused by the chronic pain and that in turn amplifies the perception of pain. He does not explain why he favours this diagnosis over a diagnosis that the psychiatric condition was a pre–existing condition.

148. Dr McLaren's evidence is also of little value to the Court as he makes significant assumptions in his report and he accepted in cross examination he made those assumptions, regarding the Worker's prior mental state on the basis that she would not talk to him about any family history. He opins that as the Worker was reluctant to talk about her family, she must therefore not be close to her family and without that closeness, she would have been leading a socially isolated life prior to the work injury. Is the Doctor saying that anyone who doesn't have a close family leads a socially isolated life? This assumption clearly should not be made without some supporting evidence. It is interesting to note however that Dr Walton accepts the possibility that:

> "there is a contribution to this woman's psychological problems from the conflict in her family of origin but that has been quite longstanding, did not produce troublesome psychological symptoms previously, and I would rate any such contribution as being quite minor"

149. I find neither of the psychiatric reports to be of great assistance, neither psychiatrist has provided the Court with sound reasoning for their diagnosis of the cause of the Worker's anxiety and depression. Dr Isherwood–Hicks also just accepted that the symptoms were caused by the Worker's inability to adjust to the loss of her employment as a patient carer, without investigating whether there may be other causes. Dr Isherwood-Hicks also suggests that the Worker's psychological condition should improve once she has had her Work Health claim resolved.

150. The ultimate question is whether this Court accepts the Worker has the symptoms as she describes, does she have the continuing problems with her right hand and arm, left hand and arm and psychiatric symptoms? Further if those symptoms exist can they be casually linked to the original work injury?

151. Ms Newton presented in the witness box in a quiet manner, at times crying in cross examination when asked about her mental state however she was defiant when challenged about exaggerating her pain. When specifically put to her that she had been exaggerating her pain she answered defiantly "have I?" showing a glimpse of the anger mentioned in the psychiatric and psychologist reports before the Court. When cross examined about her description of her symptoms to various doctors and what she told them, she was vague in her answers often saying "I don't recall" and then reluctantly conceding that if the doctors had made a note of their conversations with her that is what she had said. In cross examination the Worker was questioned at length about the history she gave to various doctors and her ability to do certain tasks.

152. The Worker's vagueness about what she said to different doctors can be explained by the passage of time, the fact that she had seen several doctors over a period of three years and that she is on medication which affects her ability to think clearly. These factors cannot explain her reluctance to accept that if the doctors had made notes of what she told them, that is what she told them. She only made that concession when pressed in cross examination.

153. Her reports of symptoms in her left hand progressed and changed over time and while originally diagnosed by Drs Goodhand, and Mah, and pleaded by the Worker, as an overuse issue it was later diagnosed as a development of mirror symptoms of Complex Regional Pain Syndrome Type 1 by Dr Olsen and a chronic pain syndrome by Dr Champion.

154. Both Drs Haynes and Olsen dismissed the theory that the continued pain and disability experienced by the Worker in her left hand as caused by overuse. Dr Haynes, an occupational physician, gave the opinion that the left arm symptoms are more likely a result of the arthritis.

155. The fact that the inconsistencies in the Worker's responses to tests as described above and her exaggerated responses to the pain she was feeling, 20/10, the claim that medication did not assist her pain levels (as she reported to Dr Thoo), yet she continues to use pain medication, her inconsistent results in the functional capacity assessment and the uncertainty in the medical diagnosis of her condition are all indications that her symptoms are not as she reports them to be.

156. Her continuing bilateral condition is put as a rare bilateral manifestation of CRPS Type 1, yet the expert in that field, Dr Champion, does not accept that diagnosis and suggests a MRI of the cervical spine should be undertaken (see para 9 of his report of 2 June 2008) to investigate whether prior motor vehicle accidents may contribute towards her condition. It is accepted that Dr Champion did not think that the prior neck injuries were contributing,

however he did think it was worth investigating. Dr Thoo also suggested that the bilateral symptoms in the upper arms were suggestive of an issue in the cervical spine.

157. The fact that there was objective evidence of arthritic changes in both hands and that there is blind emphatic denial, in cross examination, by Dr Champion that arthritis could be contributing to the Worker's condition, where according to other doctors it is clearly a possibility, places some doubt on the objectivity of Dr Champion as an expert in a developing field. There is no evidence that the Worker has been treated for arthritis and therefore no evidence that the condition has been eliminated as a cause of her continuing pain.

158. Dr Champion also accepted that there could be some exaggeration but he could not detect it.

159. In relation to the Worker's claim regarding her consequential injuries, I cannot be satisfied on the balance of probabilities that the Worker suffers the symptoms in her left hand and arm as she claims, the inconsistencies in her responses to tests, the doubt in the medical experts of the voracity of her claims of pain levels and the difficulty of the experts to explain all of her symptoms with a diagnosis (even CPRS Type 1 is not completely supported by the recognised expert in the field), the Worker's reluctance to accept what the doctors had reported and her defensiveness in giving evidence about her pain levels, all tip the scales in favour of the argument that she is exaggerating her symptoms deliberately.

160. There was some suggestion by Dr Olsen that her exaggeration may not be conscious however there is no evidence before this Court to support the view that there is an unconscious exaggeration, to the contrary two of the doctors who directly commented on this issue said that it is likely in a medico legal context that there is conscious exaggeration so the person is

believed (see Dr Champion at paragraph 10 of his report and Dr Haynes at page 3 of his report of 23 June 2008).

161. In relation to the physical injury claim, this is not a matter where I can simply prefer the diagnosis of one doctor over the other based on their level of expertise because it is a matter where the inconsistent and unusual symptoms reported by the Worker do not really fit with any of the diagnoses given and that is accepted by all of the doctors.

162. Even if I were satisfied on the balance of probabilities that the Worker does have the symptoms she claims to have in both hands, the evidence is such that there is cogent medical evidence from Dr Thoo that her difficulties may be caused by the prior injury to her neck. This is supported by Dr Champion suggesting a MRI should be done of the neck to eliminate the neck as a cause of the symptoms and the intermittent symptoms in the neck and shoulders.

163. While CPRS is an accepted medical condition, it is a syndrome and therefore by definition, a condition diagnosed by the presence of "a group of symptoms and signs, which considered together, are known or presumed to characterise a disease" (see Gould's Medical Dictionary 4th edition). It is also a condition which is "excluded by the existence of condition that would otherwise account for the degree of pain and dysfunction" (see the print out from the International Research foundation website attached to Dr Olsen's report).

164. The collection of symptoms as described by Dr Champion did not include any changes in colour or sweating in the hands during his examination nor did he notice any deformity in her nails, whereas Dr Olsen says he does notice that deformity and he examined the Worker two months earlier. Neither of the doctors commented on whether the manifestation of the Worker's development of the symptoms of this syndrome is going to improve over time with or without treatment. Although Dr Champion did

state you would not expect all symptoms to be necessarily present all of the time, nevertheless he still did not accept Dr Olsen's diagnosis. There is no evidence of any treatment been given for this condition, nor any explanation of whether these symptoms may change over time.

165. The evidence is that there are other possibilities which may be contributing to the Worker's bilateral condition in her arms, arthritis and/or neck issues and they have not been excluded by any testing or treatment. Until these possibilities have been properly explored. then the diagnosis of CPRS Type 1 in both arms must, by definition, be in doubt. While the evidence supports the possibility of a chronic pain syndrome, it does not, in my view, support the probability of that condition and therefore, I cannot be satisfied on the balance of probabilities that the condition of CPRS Type 1 exists in the Worker's left arm or that there is a reasonable explanation for the group of symptoms which link them back to the original injury to the right thumb.

166. It is my view that all of the inconsistencies in the Worker's test results, doctors' opinions and Worker's description of her symptoms to the doctors support the view that the worker is exaggerating her symptoms in her right hand and feigning the symptoms in her left hand. Even if it is accepted that the left arm symptoms exist, the doubt cast over the diagnosis of bilateral CPRS Type 1 because of a failure to exclude other possible reasons for her symptoms, there is not enough evidence to satisfy me that these symptoms are causally linked to the original injury.

167. In relation to the psychiatric claim, the reports from Drs McLaren and Walton support the claim that the Worker has anxiety and depression, however I cannot accept either of the doctors' explanations for the cause of that condition because in my view, both of the doctors make assumptions in their diagnosis which cannot be relied upon by the Court in relation to the causal link between the original injury and the Worker's psychiatric condition.

Employer's Counterclaim

168. The invalidity of the notice and the finding that the "consequential injuries" are an exaggeration by the Worker and do not have a causal link to the original work injury, does not end the dispute, the Employer has filed a counterclaim claiming the Worker has an ability to undertake alternative employment and applies for:

> "(a) a declaration that the Worker is presently partially incapacitated for work and has been fit for suitable alternative duties since at least 17 May 2007.
>
> (b) A declaration that the Worker has an earning capacity that is equivalent to or exceeding her indexed NWE as at 17 May 2007 to date and continuing
>
> (c) In the alternative, a declaration as to the level of the Worker's earning capacity as at 17 May 2007 to date and continuing"

169. The Employer claims that while the Worker remains partially incapacitated for work as a personal care assistant, she is able to undertake other work and pursuant to section 65(2)(b)(ii) she is deemed to have an earning capacity which is greater than her indexed NWE. The Employer has the evidential burden to satisfy the Court on the balance of probabilities that the Worker does have the capacity to earn as claimed by them.

170. The Employer relied on the assessment by Dr Mah and Dr Haynes that should the Worker avoid heavy lifting and repetitive work involving the use of her hands, she is capable of 37 hours per week in alternative employment. Each of those doctors came to that conclusion based on the Worker's disability in relation to her right hand and with reference to a Functional and Vocational assessment undertaken by KONEKT neither of which were before the Court.

171. The Worker was cross examined in depth about the different duties of a receptionist, retail sales assistant, make up sales assistant and welfare worker and her answer to whether she could do specific tasks was yes to

most tasks. In re-examination she was asked to clarify what she meant by yes and questioned whether she could do some of those duties on a regular or repetitive basis to which she inevitably answered no. Unfortunately for both parties this line of questioning was not particularly helpful because it only showed that the Worker could undertake these tasks somewhere between once a day to several times a day. There was no specificity given to "regular" or "repetitive" and therefore the answers given by the Worker to those questions was based on her understanding of what is "regular" or "repetitive". The Worker was not asked to explain what she believed those terms to mean.

172. The Vocational assessment by KONEKT in October of 2006, after the two surgeries by Dr Mah and taking into account the limitations the Worker was reporting in both arms, indicated that the Worker may be able to work as a teacher's aide, retail assistant or welfare worker if not full time, part time.

173. The Vocational assessment was considered by Dr Mah and Dr Goodhand and Dr Haynes all of whom agreed that the Worker had some capacity to earn given her right armed symptoms. Dr Haynes, an occupational physician, was of the view that the Worker was fit

> " … for a variety of duties where she can avoid forceful gripping and heavy lifting using her right hand. In my opinion she could undertake a variety of work as a sales assistant or sales representative or reception or clerical duties".

174. Dr Haynes was also of the opinion that the Worker could undertake some work as a sales assistant, welfare worker or teacher's aide. His assessment of the Worker's capacity to work was subject to restriction relating to her right hand. This assessment corroborated Ms Clee's assessment of the Worker's capabilities in her Vocational assessment and accorded with Dr Mah's assessment of the situation. Dr Haynes was subject to cross examination on his work history and challenged as to why his resume did not include his time working for an insurance company assessing worker's

compensation claims. The implication the Worker's counsel was making is that Dr Haynes had a biased view in relation to the Worker's claims for benefit and that he was more likely to diagnose in the interest of the insurer. I do not accept that implication. If Dr Haynes was the only person suggesting the Worker had a capacity to earn I might have found that implication more acceptable but in fact others were of the opinion that the Worker had a capacity to earn at least on a part time basis as I have referred to above.

175. Mr Woodside's evidence was that in his experience and observation a teacher's aide was not required to do any heavy lifting nor were they required to undertake duties which they may not be capable. He gave evidence that some teacher's aides were not full time and it depended on the requirements of the school. He confirmed in examination in chief and cross examination the duties of the teacher's aide in the classroom were up to the teacher in that classroom. Mr Woodside was cross examined as to the different duties a teacher's aide may be required to do with reference to a job specification for a teacher's aide produced from the NT government website and some of those duties were in conflict with what he perceived a teacher's aides role to be within the classroom.

176. Mr Woodside was subjected to vigorous cross examination as to the duties of a teacher's aide and was not shaken as to what his experience was of those duties. He did concede that a person with depression and problems with using both hands may have a difficulty in doing the job, however emphasised that it is the sort of job which did not require repetitive use of hands nor heavy lifting. Counsel tried to attack the voracity of Mr Woodside's evidence as to what was actually required of a teacher's aide, however she was unsuccessful in that attempt. Mr Woodside was an honest and straightforward witness and clearly was giving evidence of his own experience as a teacher of long service.

177. The evidence of both Ms Morgan and Ms Hulands supported the view that a person with limited use of one hand, limited computer literacy and average intelligence with relevant on the job training would be able to undertake the duties of a receptionist and/or sales assistant in a pharmacy. The cross examination of these lay witnesses elicited evidence that a person with all of the disabilities the Worker was claiming she had, may find it difficult to obtain work in those areas but also elicited that the duties could be modified to suit some disabilities and any training would be mainly on the job training. They saw limited use of both hands with depressed mood may not make a person suitable for the job, but that decision really depended on the particular employer and what requirements they had of the person.

178. The evidence produced through Mr Stinton, a labour market analyst, gave the Court information on the average weekly earnings of a worker in these categories in the Northern Territory. The evidence was challenged by counsel for the Worker on the basis that Mr Stinton had not produced the raw data upon which he relied. Mr Stinton advised the raw data was attained from an Australian Bureau of Statistics source, which was available to anyone who was prepared to pay for the information, married with information from the Australian and New Zealand Standard Classification of Occupations (ANZSCO). It is my view that Mr Stinton explained his methods of research adequately in examination in chief and that his evidence of average wage relating to the nominated occupations is reliable. It is of note that ANZSCO is contributed to by the Australian Bureau of Statistics and Statistics New Zealand.

179. Mr Stinton was also asked to explain the skills levels referred to in ANZSCO and particularly in relation to a teacher's aide. He explained that the skill level was skill level 4 with level 1 being the highest and level 5 being the lowest. He explained that the skill level is an indication of what might be needed for the job but was not a "direct requirement" for the job. Skill level 4 was characterised by Mr Stinton as something more than

secondary education, but lower than a certificate 4 or diploma, he also explained that skill level 4 would require a certificate or relevant experience.

180. Mr Stinton used the information available to him to produce figures for average wages for several occupations.

181. It is noteworthy that the Worker did undertake part time employment as a teacher's aide in 2007 working 3 hours a day for two days a week. She completed that work for two weeks. It is not completely clear why she ceased that work, whether the work was no longer available to her, whether she could not cope physically or whether she could not cope psychologically.

182. The Worker hinted that she could not work with younger children because of their unpredictability. Her evidence was that the only difficulty she had was the children's concentration, "they were just silly 5 year olds".

183. Regarding the physical tasks as a teacher's aide, the Worker accepted that the only things that gave her difficulty, were the use of the electric pencil sharpener, getting up off the floor because she had to put pressure on her hands to get up and writing in children's books because of her different way of holding her pencil and children's enquiries about that. The Worker also said that she was tired by the end of the 3 hours.

184. The Worker clearly thought she was able to undertake the position of a teacher's aide mentally and intellectually for at least the 3 hours a day for two days a week, however was concerned about the reaction the younger children had to her pencil grip and their unpredictable behaviour and the possible consequences of one of them grabbing her hands.

185. The Worker's counsel, referring to an assessment by KONEKT that was not before the Court, and then took the Worker to certain tasks set out in the KONEKT report which were included in the description of what is required

of a teacher's aide. In answer to those questions the Worker conceded that she could do most tasks set out except for restraining a child and heavy lifting and some playground activities.

186. She also conceded in cross examination that she could do all of the tasks indicated as part of the teacher's aide work as long as it was not repetitive or regular and did not involve heavy lifting. The evidence of Mr Woodside is that a teacher's aide duties was unlikely to involve repetitive work for any length of time or heavy lifting and could be limited to accommodate these limitations. The duties of teacher's aide are wide and varied and largely rely on what the school wants that person to do. Mr Woodside also denied that a teacher's aide would be required to ever restrain a child and that even a teacher would not be required to do so. Mr Woodside was challenged on that issue, however he was emphatic and given the community's expectations and sensitivity towards teachers having physical contact with children, I accept Mr Woodside's evidence on this issue.

187. In Dr Mah's report of 6 August 2007 it is apparent that the Worker reported to him that she could not cope with the "psychological component" of the work. There is no further explanation of what he meant by that. Dr Mah also reports in that report that "I understand that she has tried a variety of jobs without success so far". The Worker's evidence does not corroborate this statement, she says the only work she has done is the light duties before her operations and that of the teacher's aide at Moulden Primary School. There is no explanation of this inconsistency by the Worker.

188. Ms Morgan's and Ms Huland's evidence was clear that a person of average intelligence could learn the duties of a receptionist and a retail assistant in a pharmacy with proper on the job training. When cross examined about the duties of each of those jobs, they too gave evidence that the duties could vary from workplace to workplace but could outline the general duties.

189. The cross examination of these lay people gained concessions from them all that if a person had all of the symptoms the Worker complained of, then she would be unlikely to be able to work full time in the position and unlikely to be employed at all if there were others more able.

190. It is clear from the evidence that if the Worker only had the symptoms relating to her right hand she would be capable of part time possibly full time work as a teacher's aide, receptionist or sales assistant.

191. Having found that the Worker's left arm symptoms are either an exaggeration by her or if they do exist, there is no causal link established between those symptoms, her psychiatric condition, and the original work injury, then it follows that I find the Worker is able to work at least part time in as a teacher's aide, pharmacy assistant or receptionist, taking into account the limitations she may have in relation to the right hand.

192. The Employer relies on section 65(2)(b)(ii) which provides:

> "2) For the purposes of this section, loss of earning capacity in relation to a worker is the difference between –
>
> (a) his or her normal weekly earnings indexed in accordance with subsection (3); and
>
> (b) the amount, if any, he or she is from time to time reasonably capable of earning in a week in work he or she is capable of undertaking if –
>
> (i) in respect of the period to the end of the first 104 weeks of total or partial incapacity – he or she were to engage in the most profitable employment (including self-employment), if any, reasonably available to him or her; and
>
> (ii) in respect of the period after the first 104 weeks of total or partial incapacity – he or she were to engage in the most profitable employment that could be undertaken by that worker, whether or not such employment is available to him or her,
>
> and having regard to the matters referred to in section 68.

193. The Employer submits even taking into account all of the Worker's alleged symptoms, the Worker is clearly able to undertake at least part time work as a teacher's aide and if she could work 74% load then she would be earning more than her NWE. A 74% load would be the equivalent to approximately 3.5 days per week (over 5 days that would equate to school hours).

194. The calculations provided by the Employer in relation to the earning capacity of the Worker if she was a pharmacy assistant or receptionist indicates that she would have to work 90% work load (4.5 days a week) as a receptionist and 76.8% (3.85 days a week) to earn equal to her present NWE. These calculations are based on the labour market analysis provided by Mr Stinson.

195. The further submission is that because the Worker is now outside the first 104 weeks of total or partial incapacity, the Employer does not have to prove that this work is available to the Worker.

196. The Worker's submissions on the operation of section 65(2)(b)(ii) are that even though it includes the phrase "whether or not such employment is available", that phrase must be read in context with the clause "and having regard to the matters referred to in section 68". Section 68 provides:

> "In assessing what is the most profitable employment available to a worker for the purposes of section 65 or reasonably possible for a worker for the purposes of section 75B(3), regard shall be had to –
>
> (a) his or her age;
>
> (b) his or her experience, training and other existing skills;
>
> (c) his or her potential for rehabilitation training;
>
> (d) his or her language skills;
>
> (e) in respect of the period referred to in section 65(2)(b)(i) – the potential availability of such employment;
>
> (f) the impairments suffered by the worker; and

(g) any other relevant factors".

197. The Worker argues "other relevant factors" included whether the work would be available to the Worker given her disabilities. This argument cannot succeed. It is clear from the plain reading of section 65(2)(b)(i) & (ii) and the inclusion of subclause (e) to section 68 that the availability of work is only relevant when assessing the Worker's most profitable employment in relation to the first 104 weeks of incapacity. There was some suggestion that given the *Work Health Act* is beneficial legislation its provisions should be read in favour of the Worker, that is obviously only the case when there is uncertainty in the legislation on the ordinary meaning of the words and in my view there is no such uncertainty.

198. Given the inclusion of section 68(e), the legislation made it clear that the Court does not need to consider the potential availability of employment and section 69(2)(b)(i) & (ii) specifically refers to "most profitable employment that could be undertaken by that worker, whether or not such employment is available to him or her".

199. The availability of a type of employment to the Worker given her disabilities is a relevant consideration after the first 104 weeks of incapacity but the availability of work, part time or otherwise, on today's market is not.

200. The Worker's disabilities, age, skills etc have to be considered in relation to her most profitable employment she could undertake and the cross examination of the Worker to address her physical capabilities as well as her intelligence levels. The Worker clearly doesn't have strong computer literacy, however she accepted that with training she could obtain those skills. All of the forms of employment suggested by the Employer as suitable for the Worker given her disability in her right hand and even taking into account her emotional state do not require a high level of computer literacy and relied on training on the job for those sorts of skills if not already acquired by the Worker. There is also cogent evidence put

before the Court that all of those occupations, teacher's aide, receptionist and retail assistant are flexible in the duties and hours required of a Worker.

201. There is a suggestion by the Worker that her ability to work is also influenced by her use of strong painkillers and sedatives, however as it has not been accepted that she suffers the level of pain she professes to have, then the level of medication and its effect must be discounted.

202. It is also suggested by the Worker that her psychological well being would prevent her from having the ability to undertake these occupations. Even if it is accepted that the Worker does have psychological difficulties, there is no evidence from the psychiatrist or psychologist that it prevents her from working totally. Dr Walton states that in his opinion the Worker has a 30% incapacity for employment contributable to the psychiatric condition. Of course as I have not been satisfied on the balance of probabilities that the psychiatric condition is causally connected to the work injury, therefore Dr Walton's assessment is not relevant to the assessment of the Worker's capacity to earn in relation to that work injury.

203. To the contrary, Dr Isherwood–Hicks is of the opinion that a resolution of the Work Health claim may help to allow the Worker to adjust to the loss of her ability to work as a patient carer. The loss of job and uncertainty of employment future is cited the reason for the psychological disability and therefore it would follow if the Worker was able to obtain employment, some of those symptoms would abate and therefore not affect her capabilities at work.

204. The Worker's most profitable employment must be considered in the context of the effect her work injury has had on her work capacity. If the Worker's disabilities are limited to the right arm issues, then her most profitable employment is going to be broader than if the left arm symptoms and psychological symptoms are accepted.

205. The question for this Court is whether I am satisfied on the balance of probabilities that the Worker has the capacity to undertake the duties of those occupations. Discounting the left arm and psychiatric symptoms, I am satisfied she has that ability to undertake the duties required of a receptionist or a teacher's aide, at least to the level on a part time basis that would pay her more than her agreed NWE.

206. The evidence is that she is able to physically undertake all of the duties of the those two occupations with the limitations that she does no heavy lifting and is not required to do repetitive work with her right hand. The evidence from the Worker that she could do the duties as long as they are not "repetitive or regular". The evidence of Dr Mah is that she can undertake full time work on restricted duties. Drs Haynes and Goodhand, in reference to the KONEKT report, indicate that given appropriate duties they were of the opinion the Worker could return to work on alternate duties and neither of them limit the hours that could be worked. Of course I have not given any weight to the nominated occupations in the KONEKT report because that report was not put before the Court, however there is independent evidence of what is required of people employed as teacher's aides, receptionists and retail assistants and it is with that evidence before me I make the finding of the Worker's partial capacity to work.

207. The Worker is partially incapacitated to work as patient carer because of her inability to lift heavy weights and to use her right hand in a repetitive way eg for showering patients. However it is my finding that even in her limited capacity, she has the ability to earn more than her agreed normal weekly earnings.

208. Therefore pursuant to section 69(2)(b)(ii) of the *Work Health Act*, the Worker is not entitled to further weekly benefits.

Vehicle Modifications and Home Care Assistance

209. With the findings that the Worker is exaggerating her symptoms in her left arm, it is clear that Ms Hardiman's assessment of what is required as home help is put into doubt. Ms Hardiman was not asked to assess the need for home care hours given the Worker only had problems with her right arm. Therefore I cannot be satisfied as to the level of assistance the Worker requires. That is not to say that I am of the view no assistance is needed, I just cannot quantify that level of assistance given the state of the evidence.

210. It is accepted that the Worker's problems with her right hand affect her ability to drive. It is also clear that should she have the symptoms in her left arm as she claims, then an automatic vehicle may be required. The Employer disputes the cost of the purchase of an automatic vehicle to address those problems. It was suggested that a conversion of the Worker's old car would have been sufficient. The evidence of Mr Bond is clear that it would have cost a considerable amount of money to convert the old manual car to an automatic and it was better use of money to purchase an automatic. Given the age of the Worker's car, I accept Mr Bond's assessment. I also accept that the Worker' difficulties with her right hand require her to have electric windows on her vehicle. I cannot find however that the right hand symptoms require the Worker to have an automatic car as it is clearly the left hand that is used for changing gears on a manual.

211. The installation of the knob steering wheel clearly assists the Worker in driving and I am satisfied that the limitations in her right hand justify that installation.

Conclusion

212. Given the above the orders of this Court will be as follows:

    1. Declaration that the Notice of Termination of benefits served on the Worker is invalid for failing to comply with sections 69(3) & (4) of the *Work Health Act*.

2. The left arm symptoms claimed by the Worker are not causally linked to the original work injury and therefore do not constitute an injury consequential upon the original injury to the right hand.

3. The Worker's psychiatric symptoms are not causally linked to the original work injury.

4. The Worker is presently partially incapacitated for work and has been fit for suitable alternative duties since at least 17 May 2007.

5. The Worker has an earning capacity that is equivalent to or exceeding her indexed NWE as at 17 May 2007 to date and continuing.

6. The Worker's claim for further weekly benefits is dismissed.

7. The Worker's claim in relation to underpaid travel expenses is dismissed for lack of evidence.

8. The Worker's claim for an order that the Employer pay the Worker's ongoing medical expenses in relation to the injury to her right thumb is unnecessary by virtue of the operation of the Act.

9. The Worker's claim for a declaration for further payment of medical and rehabilitation expenses in relation to the original injury is unnecessary by virtue of the operation of the Act.

10. Any claim for travel, rehabilitation or medical expenses relating to the left arm and psychiatric symptoms is dismissed.

11. The Employer pay the Worker's cost of vehicle modification to include a "turning wheel on the steering wheel of her car" and wide side mirrors, however given the finding that the left arm symptoms do not exist, any claim for the purchase of an automatic vehicle is dismissed.

12. The Employer pay for the provision of reasonable home care assistance for the Worker in relation to her disability in her right hand.

13. The Worker's claim for interest on outstanding payments is dismissed.

14. Costs are reserved.

Dated this 27th day of August 2008.

_____

Tanya Fong Lim
RELIEVING STIPENDIARY MAGISTRATE