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Editor's notes

This issue marks a new era for *VeRBosity* now in its twenty-first year. We will now also include articles, and report on cases under the SRCA, that relate to issues relevant to matters under the MRCA.

By the end of the 2005-06 financial year, the Board had been notified of 11 applications for review that had been lodged under s 352 of the *Military Rehabilitation and Compensation Act 2004* (the MRCA). Only 2 applications had been made under the MRCA in the 2004-05 financial year.

These cases concern a variety of new and interesting issues for the VRB.

One of these new issues concerns claims for injury or disease said to be the result of an unintended consequence of medical treatment obtained under the Defence Force Regulations or the MRCA. An article on that issue is included in this edition of *VeRBosity*. There is also a case note on *Re Parker*, in which this issue was raised in the context of the Military Compensation and Rehabilitation Scheme under the *Safety, Rehabilitation and Compensation Act 1988* (the SRCA).

As always, comments, questions and feedback on any aspect of *VeRBosity* are most welcome.

Trina McConnell
Editor

Defence service under the VEA

Background

Eligibility for **'defence service'** was introduced in Repatriation legislation in 1973, and backdated to 7 December 1972, the date of the announcement by the Whitlam government that:

- conscripted members who completed their term of National Service; and
- full-time members of the ADF who had rendered 3 years **'effective full-time service'**,

would be eligible for Repatriation benefits.

In 1986, the VEA continued eligibility for such defence service but provided that it would terminate upon the establishment of a Military Compensation Scheme.

That Scheme came into operation on 7 April 1994 upon the commencement of the *Military Compensation Act 1994*.

Sections 68 and 69 of the VEA

Section 68 defines 'defence service' and 'effective full-time service'.

Section 69 states that the VEA applies only to certain members who have rendered defence service. Not everyone who has rendered 'defence service' is eligible under the VEA. The only members eligible are those identified in s 69 as being members to which Part IV of the VEA applies.

Service on or after 7 December 1972

Defence service is defined as continuous full-time service rendered on or after 7 December 1972 and before the **'terminating date'** (7 April 1994).[1] This definition must be considered in light of further conditions relating to eligibility in sections 68 and 69.

The terminating date does not bring defence service to an end if the member continued to render continuous full-time service from before the commencement of the VEA (22 May 1986).[2]

If there was a break in service between 22 May 1986 and 7 April 1994, service on or after 7 April 1994 is not 'defence service'. If there is a break in service after 7 April 1994, then any service rendered after that break is not 'defence service'.

Section 70A of the VEA effectively brought all 'defence service' to an end on 30 June 2004.

3 years effective full-time service

Except for members completing their term of National Service[3] or rendering hazardous service,[4] a basic eligibility requirement for 'defence service' is that the person rendered 3 years effective full-time service.[5]

Effective full-time service is any period of continuous full-time service other than

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[1] Para (a), definition of 'defence service', s 68(1).

[2] Para (b), definition of 'defence service', s 68(1).

[3] The 3 years effective full-time service requirement does not apply if the member had been conscripted and completed their term of National Service under the *National Service Act 1951*: see s 69(1)(f).

[4] Subsection 69A(1).

[5] Subsection 69(1).

any period of more than 21 consecutive days in which the person was: [6]

- on leave of absence without pay;
- absent without leave;
- awaiting or undergoing trial in respect of an offence of which the member was later convicted;
- undergoing detention or imprisonment; or
- an officer who was engaged in study on appointment and was not regarded by the ADF as rendering effective full-time service while engaged in that study.

The 3 year period of effective full-time service could have commenced before 7 December 1972. For example, if a member served from 1968 to 1973, the member would have eligibility for the period from 7 December 1972 to the date of discharge in 1973. The full-time service rendered before 7 December 1972 counts towards the 3 years effective full-time service, but is not 'defence service'.

If a person had more than one period of defence service, each subsequent period must have satisfied the eligibility requirements if it did not immediately follow the earlier period.[7] For example, each period that was separated in time from an earlier period must involve at least 3 years effective full-time service.

Part-time service excluded

As 'defence service' is defined in terms of 'continuous full-time service', it means that it does not include part-time service.

Peacekeeping service excluded

Defence service does not include any period of 'peacekeeping service', but such service counts as 'effective full-time service'.

Hazardous service included

Defence service includes any periods of 'hazardous service', whether before or after the 'terminating date'.

Medical discharge exceptions

If a member died or was discharged for a medical reason, the requirement to complete the term of national service does not apply.[8] Similarly, the requirement to complete 3 years effective full-time service does not apply if the person died or was discharged for a medical reason.[9]

If it can be shown that the real reason a person was discharged was a medical condition, it does not matter that the formal reason was something else.[10]

Proviso to the medical discharge exception

If a member is discharged for a medical reason within 12 months of enlistment or appointment, the medical discharge exception to the 3 year rule does not apply if the discharge was caused or substantially contributed to by a medical condition that existed when the person commenced continuous full-time service and had not been aggravated by that service.[11]

[6] Definition of 'effective full-time service' in s 68(1).

[7] Subsections 69(2), (3).

[8] Sub-sub-para 69(1)(f)(ii)(B).

[9] Paras 69(1)(d), (e).

[10] *Whiteman v DVA* (1996) 141 ALR 106, 12 *VeRBosity* 77

[11] Subsection 69(5).

Unintended consequence of medical treatment (MRCA)

Background

The *Military Rehabilitation and Compensation Act 2004* (the MRCA) includes a concept of acceptance of liability for an injury or disease that was the unintended consequence of medical treatment obtained under the Defence Regulations or the MRCA.

This is an extension of a provision that was first introduced in the *Safety, Rehabilitation and Compensation Act 1988* (the SRCA) in 1994. Section 6A of the SRCA deemed an injury that was the unintended consequence of medical treatment obtained at Commonwealth expense to have 'arisen out of or in the course of employment'.

Section 29 of the MRCA provides:

> **29 Definitions of *service injury*, *service disease* and *service death* arising from treatment provided by the Commonwealth**
>
> *Liability for injuries and diseases caused by treatment*
>
> (1)For the purposes of this Act, an injury sustained, or a disease contracted, by a person is a ***service injury*** or a ***service disease*** if:
>
> (a) either:
>
> (i) the person receives treatment under this Act for an earlier service injury or disease and the treatment is paid for or provided wholly or partly by the Commonwealth; or
>
> (ii) the person receives any treatment under regulations made under the *Defence Act 1903*; and
>
> (b) as an unintended consequence of that treatment, the person sustains the injury or contracts the disease.
>
> *Liability for injuries and diseases aggravated by treatment*
>
> (2) For the purposes of this Act, an injury sustained, or a disease contracted, by a person is a ***service injury*** or a ***service disease*** if:
>
> (a) either:
>
> (i) the person receives treatment under this Act for the service injury or disease and the treatment is paid for or provided wholly or partly by the Commonwealth; or
>
> (ii) the person receives any treatment under regulations made under the *Defence Act 1903*; and
>
> (b) as an unintended consequence of that treatment, the injury or disease, or a sign or symptom of the injury or disease, is aggravated by the treatment.
>
> *Liability for deaths caused by treatment*
>
> (3) For the purposes of this Act, the death of a person is a ***service death*** if:
>
> (a) either:

(i) the person receives treatment under this Act for a service injury or disease and the treatment is paid for or provided wholly or partly by the Commonwealth; or

(ii) the person receives any treatment under regulations made under the *Defence Act 1903*; and

(b) as a consequence of that treatment, the person dies.

What treatment is covered?

The treatment that is covered by s 29 is:

- treatment for a ***service injury or disease*** under the MRCA; or
- ***any*** treatment under the Defence Regulations.

Former members who have a Gold Card for treatment under the MRCA are entitled to be treated for any injury or disease, whether it is a service injury or disease or not. However, s 29 will not apply if the person is treated for a non-service injury or disease under the MRCA.

Members of the ADF are entitled to treatment for any injury or disease, whether a service injury or disease or not, under Defence Force Regulations. Regulation 58F of the *Defence Force Regulations 1952* provides:

58F Provision of medical and dental treatment

(1) Subject to subregulation (2), the Commonwealth must provide the medical and dental treatment required to keep a member healthy for the purpose of discharging the member's duties.

(2) The Minister may determine, in writing, conditions on which the treatment is to be provided to a member, having regard to:

(a) the treatment facilities available under the circumstances (including the place where the member is serving); and

(b) the duties of the member; and

(c) the operational requirements of the Defence Force.

Section 29 of the MRCA potentially applies in relation to any treatment obtained under r 58F.

What is a consequence?

If X is a 'consequence' of Y, then X has been *caused* by Y.[12] If an injury or a disease is a consequence of treatment, it must have been caused by the treatment, and not merely be an injury or disease that arose during or in the course of the treatment. Causation must be established on the balance of probabilities.

The following cases provide examples of what have been held *not* to be consequences of treatment:

- In ***Re King***,[13] the AAT found that the death of the tooth may have been able to be prevented if those treating the applicant using a banding procedure had not overlooked the need for X-rays and, with the

[12] *American Home Assurance Co v Saunders* (1987) 11 NSWLR 363

[13] *Re King and MRCC* (2005) 83 ALD 322

assistance of appropriate X-rays, had found the fracture and referred Mr King for endodontic treatment. On the evidence, that was no more than a mere possibility. Similarly, there was no evidence that the tooth probably died in consequence of the banding treatment.

- In ***Re Price-Beck***,[14] the AAT noted that a failed root canal treatment caused by reinfection of the tooth was not necessarily a consequence of the treatment performed, but rather occurred in spite of it. The AAT found that the infections experienced over the years were as a consequence of residual bacteria that remained in the tooth *in spite* of any treatment aimed at removing it. The infection in the tooth was caused from the initial blow to the tooth which disrupted the blood supply and allowed bacteria to form. That bacteria remained despite any efforts to remove it via root canal therapy. The AAT found that the infection was a consequence of the bacteria that remained in the tooth and could not be said to be a consequence of any medical treatment performed.
- Similarly, in ***Re Penny***,[15] the treatment was designed to repair a fractured tibia and to prevent infection even though there was a high likelihood that the plating procedure would result in osteomyelitic infection. The introduction of that infectious agent into the right tibia was not designed or aimed for. Nevertheless, the likelihood of its occurrence was foreseen and preventative treatment was administered. It was an occurrence despite the administration of preventative treatment. It was an injury that was neither unavoidable nor outside the realm of probability in the circumstances at the time. The infection happened *despite* treatment rather than *because* of it.
- ***Re Elliott***[16] concerned alleged aggravation of a disease by treatment. The applicant was treated with anti-inflammatory drugs for psoriatic arthritis. The AAT found that even if treatment with other drugs may have delayed the erosive effect of the psoriatic arthritis, the treatment provided to the applicant did not contribute to the progression of the disease. The results that flowed from that treatment, while they did not halt the progression of the disease, did not contribute to the progression of the disease.

What is an 'unintended' consequence?

A number of cases have considered the meaning of 'unintended consequences' under the SRCA.

The leading case, ***Comcare v Houghton***,[17] indicates that the process involves a number of steps:

[14] *Re Price-Beck and Comcare* (2003) 74 ALD 187, [2003] AATA 386

[15] *Re Penny and MRCC* [2004] AATA 1004

[16] *Re Elliott and Comcare* (2001) 64 ALD 423, [2001] AATA 305

[17] *Comcare v Houghton* [2003] FCA 332

1. Identify the injury or disease that is said to have resulted from the treatment;
2. Decide whether that injury or disease was caused by the treatment and was not merely associated with the treatment;
3. Decide whether the injury or disease was 'unintended'.

Being 'unintended' requires more than that it was undesired. A result is *not* 'unintended' if it 'was, and was always known to be, an unavoidable direct consequence of the medical treatment, albeit one which those administering the treatment did not positively desire, seek or aim to produce'.

The Court agreed with ***Re Eaton***[18] that an unintended consequence is one that:

- is not desired, or aimed for, or designed by the provider of the medical treatment; and
- is **not a likely consequence** of the medical treatment.

This definition was used in the Explanatory Memorandum to the MRC Bill.[19]

What is not desired, or aimed for, or designed by the provider?

The first leg of the meaning of 'unintended consequence' is that it not be desired, or aimed for, or designed by the provider of the treatment. If a particular consequence was meant to be part of the treatment process, then it cannot have been unintended.

In ***Re Eaton***,[20] the applicant's cervix was partially removed in treating her for a pre-cancerous condition. The AAT held the scarring of her cervix was not an unintended consequence of medical treatment. It was inevitable that because part of the cervix was removed, the remaining cervix would be scarred.

What is 'a likely consequence'?

The SRCA cases provide examples of what is meant by a likely consequence (and so would not give rise to liability):

- gastric erosions caused by ingestion of non-steroidal anti-inflammatory tablets were found to be 'highly likely'—***Re Glendenning***;[21]
- total hearing loss from an operation that would 'probably result' in total hearing loss, but by which there was a slim chance of preservation of hearing—***Houghton***;[22]
- damage to the facial nerve and that numbness and paresthesia to areas of the face and ear following parotidectomy were 'common known consequences' of this surgery—***Re Schoobert***.[23]

The following SRCA case provides an example of what is ***not*** a likely

[18] *Re Eaton and Comcare* (2002) 67 ALD 182, [2002] AATA 222

[19] The text of the Explanatory Memorandum for this clause is set out at page 49, below.

[20] *Re Eaton and Comcare* (2002) 67 ALD 182, [2002] AATA 222

[21] *Re Glendenning and Comcare* (2004) 78 ALD 723, [2004] AATA 6

[22] *Comcare v Houghton* [2003] FCA 332

[23] *Re Schoobert and MRCC* [2004] AATA 1087

consequence of treatment (and so might give rise to liability):

- blindness following a surgical procedure. In this case, blindness would likely have occurred whether the operation happened or not; the success rate for the operation was low; but the risk of adverse results caused by the operation itself were rated at between 5% and 10%. Blindness caused by the operation was considered ***not*** to be likely where the risk of such a consequence was between 5% and 10%: ***Re Parker***. (It should be noted that while the Tribunal accepted liability for the blindness, it found that there was no permanent impairment resulting from the injury because Mr Parker would have been blind in any event due to the disease for which he was being treated, and so no permanent impairment compensation was payable.)[24]

Aggravation of an injury or disease, or sign or symptom, as an unintended consequence of treatment

Subsection 29(2) provides that an injury or disease is a service injury or disease if, as an unintended consequence of treatment, the injury or disease, or a sign or symptom of the injury or disease, was aggravated by that treatment.

Instead of the 'unintended consequence' being a new injury or disease, it is, instead an aggravation of an injury or disease or an aggravation of a sign or symptom of an injury or disease.

An injury or disease accepted on this basis becomes a 'service injury or disease', but compensation for permanent impairment or incapacity for service or work may only be payable to the extent and duration of the aggravation.[25]

Rehabilitation may be provided for the entire injury or disease once liability has been accepted,[26] and compensation for the cost of treatment may be paid while the effects of the aggravation persist.[27]

Treatment under the MRCA

There is a restriction on the particular injury or disease to which subsection 29(2) applies if the treatment was under the MRCA rather than the under Defence Force Regulations.

Subparagraph 29(2)(a)(i) indicates that the injury or disease that is aggravated must be the injury or disease that was being treated. This is indicated by the phrase, 'the service injury or disease'. The definite article, 'the', refers back to the injury or disease that is the subject of the claim. If that were not so, the indefinite article, 'an' would have been used.

This means that if the relevant treatment is treatment under the MRCA, the claimed injury or disease must be one for which liability has already been accepted under the MRCA. Presumably the only reason why a new claim for acceptance of liability would be made in relation to that injury or disease is because it was

[24] *Re Parker and MRCC* [2006] AATA 440. See the case note at page 58, below.

[25] For example, see s 70 and 72 of the MRCA.

[26] See s 43 of the MRCA.

[27] See s 283 of the MRCA.

previously accepted on the basis of aggravation or material contribution, and so compensation would have been payable only in relation to the effects of that earlier aggravation or material contribution and not for the effects of the aggravation caused by the treatment.

Treatment under the Defence Force Regulations

There is no similar restriction in s 29(2) if the relevant treatment was under the Defence Force Regulations. The aggravation caused by treatment of an injury or disease can be to *any* injury or disease, not necessarily the one being treated.

'Aggravation' by treatment is compensable but not 'material contribution' by treatment

On most occasions in the MRCA when the term 'aggravated' is used, it is used in conjunction with 'contributed to in a material degree'.[28] Subsection 29(2) does not do so. This would appear to indicate that s 29(2) applies only to the *aggravation* of an injury or disease or a sign or symptom by treatment, and *not* to the *material contribution* to an injury or disease or a sign or symptom by treatment.

What is the difference between aggravation and material contribution?

The difference between aggravation and material contribution is best explained by an example.

Section 30 of the MRCA concerns signs or symptoms that have been 'aggravated' or 'contributed to in a material degree'. If a person had a pre-existing lumbar spondylosis that caused a loss of normal range of movement, and due to an event on service the person's range of movement was limited even further but only for a temporary period (and there was no aggravation of the underlying disease), then the further limitation of the range of movement would be regarded as an ***aggravation of a symptom*** of the disease, and the lumbar spondylosis would be accepted as a 'service disease' on that basis.

If, instead, the person developed temporary sciatic pain from lumbar spondylosis as a result of an event on service (and there was no aggravation of the underlying disease), it could not be said that sciatic pain was aggravated by service because it did not exist before the event. Instead, the sciatic pain would be regarded as ***a symptom that was contributed to in a material degree*** by service, and the lumbar spondylosis would be accepted as a 'service disease' on that basis.

The non-mention of 'material contribution' in s 29(2) would appear to preclude an injury or disease being accepted as due to an unintended consequence of treatment if the unintended consequence of treatment is a ***new*** sign or symptom rather than an aggravation of an ***existing*** sign or symptom or an aggravation of the ***underlying*** injury or disease.

[28] For example, s 27(d), s 28(1)(d), s 28(2), and s 30.

Do Statements of Principles apply?

In cases to which section 29 applies, it is not necessary to meet a factor in a Statement of Principles (SoPs).

Sections 338 and 339 of the MRCA, which provide for the application of SoPs, state that they apply only to the acceptance of liability under s 23(1) or s 24(1) of the MRCA. Subsection 23(1) of the MRCA relates to the liability connections in s 27. Subsection 24(1) relates to the liability connections in s 28.

The omission of a reference to s 29 in s 23(1) and s 24(1) means that the SoPs do not apply to any connections alleged under s 29.

Standard of proof

The standard of proof that applies in all cases concerning s 29 is the reasonable satisfaction (balance of probabilities) standard.

This is indicated in the Notes to s 23(2) and s 24(2), which refer to the standard of proof in s 335(3) applying to all claims relating to s 29.

Questions the decision-maker should ask in an injury or disease case

When considering a claim alleging that an injury or disease was the unintended consequence of medical treatment, it is necessary to ask the following questions:

1. Is the alleged consequence of medical treatment an 'injury' or 'disease' (as defined in s 5), and, if so, what is it?
2. What was the injury or disease that was being treated?
3. Was the treatment obtained under the Defence Force Regulations (the treatment need not have been for a service injury or disease)?
4. Was the treatment obtained under the MRCA for a service injury or disease?
5. What was the treatment – what did it involve, and how was it administered or performed?
6. Was the claimed injury or disease caused or aggravated ***by*** that treatment? It will not have been caused or aggravated by the treatment if the claimed injury or disease or its worsening:
    - was merely coincidental with the treatment; or
    - occurred despite the treatment.
7. Was the injury or disease (or its aggravation) 'unintended' in the sense that it was neither:
    - desired nor aimed for nor designed by the provider of the medical treatment; nor
    - a likely consequence of the medical treatment?

Death as a consequence of treatment

Section 29 not only applies to injury or disease that was an unintended consequence of treatment, but also to death that was 'a consequence' of treatment.

The word 'unintended' is not used in s 29 in relation to the death of a person for the obvious reason that death is unlikely to be the desired or likely consequence of treatment, and so it is unnecessary to add the word 'unintended'. Therefore, the

test to be applied is whether death was ***caused by*** the treatment.

A claim could not be accepted if death:

- was merely coincidental to the treatment;
- occurred despite the treatment; or
- was a consequence of the injury or disease that was being treated rather than being caused by the treatment.

Questions the decision-maker should ask in a death case

When considering a claim alleging that death was the consequence of medical treatment, it is necessary to ask the following questions:

1. What was the injury or disease that was being treated?
2. Was the treatment obtained under the Defence Force Regulations (the treatment need not have been for a service injury or disease)?
3. Was the treatment obtained under the MRCA for a service injury or disease?
4. What was the treatment – what did it involve, and how was it administered or performed?
5. Was the death caused ***by*** that treatment? It will ***not*** have been caused by the treatment if the death:
    - was merely coincidental with the treatment;
    - occurred despite the treatment; or
    - was merely a consequence of the injury or disease that was being treated.

Treatment and the 'occurrence' provision

Paragraphs 27(a) and 28(1)(a) provide that an injury, disease or death that was the result of an occurrence that happened while the person was a member rendering defence service is regarded as a 'service injury, disease or death'.

If a claim for acceptance of liability based on s 29 cannot succeed because the injury or disease was not 'unintended' although it was a consequence of treatment, it might be able to succeed under s 27(a) if it can be said that the injury or disease was caused[29] by an 'occurrence' that happened while the person was rendering defence service. Whether a particular treatment can be regarded as an 'occurrence' would depend on the circumstances of each case. An 'occurrence' is something that occurs, happens or takes place that can be differentiated from ordinary day-to-day events.[30]

Additionally, the occurrence must have happened 'while' the person was a member 'rendering' defence service. Rendering defence service requires the person to be on duty or be doing something required, authorised, or expected to be done in connection with, or incidental to, the person's duties.[31] Mere enlistment in the Australian Defence Force does not constitute rendering defence service.[32]

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[29] *Repatriation Commission v Law* (1980) 31 ALR 140; *Woodward & Gundry v Repatriation Commission* [2003] FCAFC 160.

[30] *Repatriation Commission v Law* (1980) 31 ALR 140.

[31] *Roncevich v Repatriation Commission* [2005] HCA 40 (2005) 21 *VeRBosity* 105

[32] *Repatriation Commission v Truchlik* (1989) 87 ALR 263.

Is medical negligence law relevant?

Medical negligence may often be alluded to in a person's claim concerning unintended consequences of treatment, but it is not directly relevant to a claim under s 29. The elements of a claim for damages for medical negligence are:

- the existence of a duty of care;
- breach of that duty (by breaching the relevant 'standard of care');
- causation; and
- remoteness of damage.

Duty of care

A medical practitioner has a duty to take reasonable care in the treatment provided to their patient. This involves a duty to inform the patient of the risks of the relevant treatment.

Standard of care

The standard of care is determined by considering what could reasonably be expected of a person professing the relevant skill, judged at the date of the alleged negligence. Determining whether a person has breached the applicable standard of care (that is, whether the person has been 'negligent') has two components:

- foreseeability of the risk of harm; and
- the so-called 'negligence calculus'.

A person cannot be liable for failing to take precautions against an unforeseeable risk. But the fact that a person ought to have foreseen a risk does not, by itself, mean that the person was negligent in failing to take precautions against it.

If it is found that the particular risk was foreseeable, the 'negligence calculus' is used to determine what precautions the reasonable person would have taken to avoid the harm that has occurred. The calculus has four factors:

1. the probability that the harm would occur if care was not taken;
2. the likely seriousness of that harm;
3. the burden of taking precautions to avoid the harm; and
4. the social utility of the risk-creating activity.

The calculus involves weighing factors 1 and 2 against factors 3 and 4.

Causation

The causation element requires that the person's negligent action or inaction played a part in bringing about the alleged harm, in the sense that it was necessary for the harm to have occurred.

Remoteness

Even if it can be shown that the person's negligence played a part in bringing about the harm, it is necessary to assess whether the harm was too remotely connected to the defendant's conduct for the defendant to be held liable for it.

Comparing s 29 with negligence law

For s 29 to apply, there need not have been relationship between the patient and the treatment provider that imported a duty of care. Instead, the only relationship between the treatment provider and the patient is that the treatment was provided under the MRCA or the Defence Force Regulations.

The concept of standard of care is not relevant to s 29 because it does not matter what the appropriate treatment should have been, all that is relevant is what the treatment actually was that was given. Whether that treatment was reasonable or unreasonable does alter whether it caused the injury or disease or aggravation, or whether the relevant outcome was 'unintended'.

The fact that there might have been an adverse unintended consequence of treatment does not necessarily mean that the treatment was 'negligent': for example, an unintended consequence might have been a recognised but unusual risk that a reasonable medical practitioner, in consultation with their patient, would reasonably take – such a claim could succeed under s 29.

A harm caused by negligence is not necessarily an 'unintended consequence' of treatment: for example, the consequence might have been a recognised likely outcome of that type of treatment, but the treatment was not one that a reasonable medical practitioner would administer – such a claim would not succeed under s 29.

It is therefore not helpful to apply concepts relating to medical negligence when determining a claim involving s 29 of the MRCA.

Comparison with other legal systems

The UK, Canadian and New Zealand legislation concerning veterans or military compensation do not have provisions equivalent to s 29 of the MRCA.

There is a somewhat equivalent provision in the USA. Until 1997, § 1151 of Title 38 of the US Code provided that an injury, aggravation of an injury, or death is treated as 'service-connected' if it was:

> the result of hospitalization, medical or surgical treatment, or the pursuit of a course of vocational rehabilitation … awarded under any of the laws administered by the Secretary [of Veterans Affairs].

A Veterans Affairs Regulation required a claimant to prove negligence before liability could be granted. However, in *Brown v Gardiner*[33] the US Supreme Court held that the Regulation was invalid because it was inconsistent with the Statute. The Court, in a unanimous opinion, held that the section merely required a causal connection between the injury, aggravation or death and the treatment.

This meant that the section was interpreted similarly to s 29 of the MRCA as it applies to deaths, in that all it required was a causal connection, without the need for negligence. But in respect of an injury, § 1151 was broader than s 29 of the MRCA in that *any* causal link between the treatment and the injury

[33] *Brown v Gardiner*, 115 US 552 (1994); 7 Vet App [46] (1994)

or death would give rise to liability, rather than the consequence of the treatment being 'unintended'. For example, in *Frazier v Principi*,[34] liability was granted for steroid-induced diabetes because this was 'a recognized complication of high-dose steroid therapy'. Such a claim would not be granted under s 29 of the MRCA because diabetes would have been a likely consequence of the treatment.

In *Sweitzer v Brown*,[35] the claimant was injured when struck by a motorised wheelchair while waiting for a medical examination. The US Court of Veterans Appeals held that, 'any injury or aggravation of an injury, in order to be compensable under § 1151, must have resulted from the examination itself, not from the process of reporting for the examination.' However, in *Jackson v Nicholson*,[36] the US Court of Appeals for the Federal Circuit held that a person who suffered PTSD after being assaulted by another patient in a VA hospital could succeed because the term 'hospitalization' cannot be limited to treatment, but encompasses events that occur during a stay in hospital. It is unlikely that these cases could succeed under s 29 of the MRCA given that the section requires the link to the treatment, not the broader circumstance of 'hospitalisation'.

[34] *Frazier v Principi*, Case No No. 99-1406, unreported, 2 August 2002, (www.vetapp.gov)

[35] *Sweitzer v Brown*, 5 VetApp 503, 505 (1993)

[36] *Jackson v Nicholson*, US Court of Appeals for the Federal Circuit, case No. 05-7057, unreported, 30 December 2005.

In 1997, Congress amended § 1151 to provide that a disability or death is compensable if:

> … the disability or death was caused by hospital care, medical or surgical treatment, or examination furnished the veteran under any law administered by the Secretary [of Veterans Affairs], either by a Department employee or in a Department facility as defined in section 1701(3)(A) of this title, and the proximate cause of the disability or death was –
>
> (A) carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault on the part of the Department in furnishing the hospital care, medical or surgical treatment, or examination; or
>
> (B) an event not reasonably foreseeable.

This amendment effectively restored the effect of the Regulation that had been declared invalid. This makes the US provision more restrictive than s 29 of the MRCA as it involves considerations of negligence, fault, and foreseeability.

Conclusion

Section 29 of the MRCA provides a generous extension of liability that is not available under the VEA. This provision has wider application than its counterpart in the SRCA (s 29 of the MRCA applies to both an 'injury' and a 'disease' while s 6A of the SRCA applies only to an 'injury'). Nevertheless, the SRCA cases give valuable guidance for MRCA decision-makers provided they recognise the limitations of the SRCA case law and the distinctive features of the MRCA.

The Explanatory Memorandum

The Explanatory Memorandum to clause 29 of the MRC Bill provided:

> **Clause 29 – Definitions of service injury, service disease and service death arising from treatment provided by the Commonwealth**
>
> *Liability for injuries and diseases caused by treatment*
>
> Subclause (1) covers an injury, disease death [sic] that arises from the treatment provided at Commonwealth expense to a member or former member where it is the unintended consequence of the treatment. The ADF can pay for treatment of a serving member under a provision of the *Defence Act 1903* or any regulations under that Act. If an outcome of that treatment is a new injury or disease that was an unintended consequence then the resultant injury or disease is a service injury or service disease, irrespective of whether the original condition being treated was compensable. Full compensation benefits under the Bill are payable for the resultant service injury or service disease.
>
> *Liability for injuries and diseases aggravated by treatment*
>
> Similar coverage is provided if there is an unintended consequence of any medical treatment that is paid for or provided under Chapter 6 of this Bill for a previously accepted service injury or disease. If the service injury or service disease resulted from treatment provided in the ADF, a decision by the Commission to take over that treatment from the ADF means that the Commission also assumes responsibility for meeting the ongoing treatment costs. The unintended consequences of treatment under the Gold Card for non-accepted conditions for members and dependants do not mean that the consequence becomes a service-related condition in any instance.
>
> An intended [sic] consequence is one that must be both:
>
> - not desired or aimed for by the provider of the medical treatment, and
> - not a likely consequence of the medical treatment.
>
> It does not encompass an injury which was, and which was always known to be, an unavoidable outcome of the medical treatment albeit one that those administering the treatment did not seek or aim to produce.
>
> Subclause (2) provides that where the Commonwealth pays for the treatment, as defined in subclause (1) and an aggravation of an injury or disease is the unintended consequence of that treatment, the injury or disease is a service injury or service disease but only to the extent of that aggravation.
>
> *Liabilities for deaths caused by treatment*
>
> Subclause (3) provides that where the Commonwealth pays for the treatment, as defined in subclause (1) and the outcome of that treatment is the death of the member then the death is a service death. Clause 29 only allows acceptance of the death where it is a consequence of the treatment, not just something that happens during the course of the treatment.

Administrative Appeals Tribunal

Re Oxley and Repatriation Commission

McCabe, Senior Member

[2006] AATA 350
12 April 2006

Whether 'defence service' – whether discharged on medical grounds

Mr Oxley served in the Australian Army from 30 April 1986 until 29 June 1988; and in the RAAF from 19 June 1991 until 31 May 1994. He made a claim for pension, which was rejected on the basis that he had not served for a continuous period of at least 3 years effective full-time service, and had not been discharged on medical grounds.

In 1993, he saw a RAAF doctor who reported that Mr Oxley was distressed by frequent and sudden moves, he found his work unfulfilling, he had an interpersonal conflict while at East Sale, and at Williamtown he was required to attend sessions with a psychologist. The RAAF medical records indicated that he was physically fit and did not suggest that he was mentally unfit to serve.

Mr Oxley gave evidence that after rejection as a candidate for the RAAF police he became frustrated and sought a discharge. The AAT noted:

> [7] … He was discharged in due course without any reference in his discharge papers to a psychiatric condition. He has subsequently been diagnosed with a psychiatric condition.

It was argued on his behalf that the RAAF should have investigated his condition, and if it had, he could have been discharged on medical grounds. The AAT referred to *Whiteman v Secretary, Department of Veterans' Affairs* (1996) 43 ALD 225, 12 *VeRBosity* 77, in which it was held that the discharge documents are not definitive as to whether a person was, in fact, discharged on medical grounds. The decision-maker may go behind those documents to determined the truth or substance of the matter. The AAT said:

> [11] Mr Oxley was diagnosed with psychiatric problems some time after his discharge. He might not have been a well man at the time he left the RAAF. He was certainly experiencing behavioural problems and was receiving counselling at the direction of his superiors. It is possible that more diligent inquiries by his supervisors and the doctors who examined him at various times prior to his discharge would have identified psychiatric problems that would have affected the way in which his career was handled. Rightly or wrongly, that did not occur. Mr Oxley's supervisors did not in fact form the view that Mr Oxley was not fit for service. He asked for a discharge, and he was given one. He cannot satisfy the words of s 69.

Formal decision

The AAT affirmed the decision under review.

Editor: see the article at page 36.

Re Robertson and Repatriation Commission

Constance, Senior Member
Gration, Member

[2006] AATA 366
26 April 2006

Generalised anxiety disorder – clinical onset – meaning of 'severe psychosocial stressor' – whether identifiable occurrence is one that evokes feelings of substantial distress – whether rendered 'defence service' – AAT members in disagreement

Mr Robertson claimed that his generalised anxiety disorder was war-caused and/or defence-caused. In a previous AAT proceeding ([2004] AATA 1143), it had been accepted as 'defence-caused' on the basis of inability to obtain appropriate clinical management. The Repatriation Commission appealed that decision to the Federal Court and, by consent, it was set aside and remitted to the AAT to be reheard.

On the rehearing, the matter was heard by Senior Member Constance and Member Air Marshal Gration AO AFC (rtd). The two AAT members did not agree on the outcome, and so, under s 42(1) of the AAT Act, the opinion of the presiding member prevailed.

Naval service

Mr Robertson joined the RAN on 31 May 1969 and was discharged on 7 December 1972. He had two trips to Vietnam.

On 27 February 1970, he was in HMAS *Yarra* when it escorted HMAS *Sydney* in Vung Tau Harbour. The ship was in harbour for 4 hours, during which time Mr Robertson was on general watch duty on the upper deck. He was armed with a rifle and was told that there could be floating mines and he should watch out for divers. He gave evidence that he felt nervous and did not know what to expect. Nothing eventful occurred and he felt relieved when the ship left the area.

On 22 May 1971, he was in HMAS *Parramatta* when it escorted HMAS *Sydney* into Vung Tau Harbour. This time, he had the role of Special Sea Dutyman and was closed up in the aft steering compartment with another seaman. They had the task to steer the ship manually if the steering system failed. According to the ship's log, they were closed up in that compartment at 0545 and were fallen out at 0638. The ship's log also records that 'No.1 SSD' were also closed up at 1045 and fallen out at 1137. Mr Robertson gave evidence that he could not remember leaving the compartment and it was his recollection that he spent 5 hours continuously in the compartment.

Mr Robertson said that he was unaware of what was happening on or around the ship, and while the other seaman was asleep, he was 'pretty anxious' and afraid of what may happen to him if something happened to the ship and he could not escape. He was conscious of the possibility of mines and divers from his previous trip. He thought of his compartment as 'a coffin' and he was scared that he was going to die. He felt extremely relieved when the ship left the area.

He gave evidence that before his service in Vietnam, he had no difficulty relating to others, he did not drink excessively and had no difficulty in sleeping. After his service in Vietnam in HMAS *Parramatta*, he did not socialise as much as he had done previously, his alcohol consumption increased, and he had trouble sleeping.

Evidence was given that while on leave in December 1971 his mood would suddenly change, he was impatient, and suffered hot and cold flushes and his hands trembled.

In January 1972, his son was badly burnt and was hospitalised. Mr Robertson was refused leave to attend his son and on 17 January 1972, he went absent without leave.

He remained AWOL until 4 November 1972. Six days later, he was sentenced to 28 days detention at HMAS *Penguin* (rather than Holsworthy) due to his anxiety disorder. During this period of detention he was seen by medical officers and underwent medical examination. On 7 December 1972, he was discharged on the ground that 'his services were no longer required'.

Consideration of Senior Member

Senior Member Constance found that a hypothesis was raised that:

- his experience of being in a war-zone in 1970, being closed up in the aft steering compartment of a warship in 1971 and being fearful of being killed or being injured and unable to escape, caused him to become anxious;
- this anxiety was manifested in disturbance to his sleeping pattern, difficulty in relating to others and an increase in alcohol consumption all within two weeks of the incident; and
- he became depressed, worried obsessively and withdrew socially and his anxiety developed into a continuing anxiety disorder.

The relevant SoP had a factor of 'experiencing a severe psychosocial stressor within the two years immediately before the clinical onset of anxiety disorder'. The term, 'severe psychosocial stressor' was defined as:

> an identifiable occurrence that evokes feelings of substantial distress in an individual, for example, being shot at, death or serious injury of a close friend or relative, assault (including sexual assault), major illness or injury, experiencing a loss such as divorce or separation, loss of employment, major financial problems or legal problems.

The Senior Member found that the visit to Vung Tau Harbour was an 'occurrence' for the purpose of that definition, and held that it was one that:

> [45] … would evoke feelings of substantial distress in an individual and did so in Mr Robertson. The objective possibility of attack is consistent with the manner in which the Navy treated ships in Operation Awkward and with what Mr Robertson was told on his first visit to the Harbour. It does not matter that this threat had not previously materialised … they were always taken seriously.

> [46] … The situation which is said to evoke the feeling of substantial distress in the hypothesis comes within the range of examples given [in the SoP]. It is at least as likely, if not more so, to evoke substantial distress in an individual than the experiencing of 'legal problems'.

Upon finding that the hypothesis was reasonable, the Senior Member considered whether it was disproved beyond reasonable doubt. He noted that Mr Robertson had given inconsistent statements about his service, and a psychiatrist had not referred to the second trip in his opinion. Another psychiatrist attributed his disorder to childhood experiences, domestic conflicts and the injury to his son. Nevertheless, the Senior Member was not satisfied that this evidence was sufficient to disprove the hypothesis beyond reasonable doubt. The Senior Member considered that Mr Robertson's generalised anxiety disorder was war-caused.

Both parties had agreed that Mr Robertson had rendered 'defence service' on 7 December 1972. The Senior Member said that he was, 'satisfied that there is a proper basis for this agreement.' But as he had found the generalised anxiety disorder war-caused, he did not deal with whether defence service aggravated the anxiety disorder.

Consideration of the Member

The Member considered that the hypothesis was that:

> The circumstances of a young, inexperienced seaman undertaking special sea duties when his ship enters harbour in an operational area could be sufficiently stressful to trigger a generalised anxiety disorder.

In considering the SoP, the Member said:

> [99] … I consider his crucial point is that the 'identifiable occurrence' must objectively be more than trivial or innocuous to fulfil the requirement for a 'severe' event similar in seriousness to the examples of the definition. Even accepting that a naïve and impressionable young sailor might subjectively imagine all sorts of distressing possibilities associated with passage through operational waters, while ruminating in a hot, cramped and noisy compartment in the course of his normal duties. I conclude that the 'identifiable occurrence' of undertaking normal – and frequently experienced – special sea duties when sailing into Harbour in the absence of any extrinsic adverse event is objectively simply not of the severity contemplated in the definition. It does not fit the examples provided, namely 'being shot at, death or serious injury of a close friend or relative, assault (including sexual assault), major illness or injury, etc'. Mr Robertson's own evidence was that he had been trained for, and had experienced many times before and after 22 May 1971, his special sea duty in the aft steering compartment. So, irrespective of whether or not Mr Robertson subjectively experienced 'feelings of substantial distress,' I conclude that the objective 'identifiable occurrence' does not 'fit the template' of SoP No 1 of 2000.

The Member then considered whether or not Mr Robertson had rendered any defence service. Both parties had agreed

that he had rendered defence service on 7 December 1972. The Member said:

> [101] I turn now to the second ground for appeal brought in relation to Mr Robertson's defence service in the RAN, during which Mr Robertson claims 'inability to obtain appropriate clinical management for anxiety disorder'. The relevant service period is only one day; ie 7 December 1972, the day on which Mr Robertson was discharged. However, I note that s 69(1)(c)(ii) of the Act requires completion of 3 years' effective full-time service before becoming eligible under Part IV of the Act. As Mr Robertson joined on 31 May 1969 and was AWOL for probably in excess of ten months, he would not have achieved the necessary 3 years by 7 December 1972. If this is correct then Mr Robertson is ineligible for access to Part IV of the Act.
>
> [102] Assuming Mr Robertson had completed 3 years' service …
>
> [104] … There is no evidence before the Tribunal suggesting that the one day of relevant service contributed materially to, or aggravated, the pre-existing condition. The appeal therefore would fail on this ground … .

The Member would have affirmed the decision under review.

Formal decision

The Tribunal set aside the decision under review and remitted the matter for reconsideration by the Commission on the basis that Mr Robertson's generalised anxiety disorder was war-caused.

Editor: The Member's argument concerning rendering 3 years effective full-time service would appear to be correct. See the article at page 36.

Re Green and Repatriation Commission

Fice, Member

[2006] AATA 397
8 May 2006

Reasonable hypothesis – kind of death – suicide – throat cancer

Mr Green served in the Army in World War 2 and in the RAAF in Japan and Korea in the 1950s. He lived outside Australia and never lodged a claim for a disability pension.

The veteran committed suicide by cutting his own throat. It was contended that he did so because he was in constant pain from throat cancer, contributed to by a service-related smoking habit or from chemicals and toxic substances to which he had been exposed as an engine fitter in the RAAF.

Mrs Green said that the veteran suffered from throat cancer but could not afford medical treatment for his condition. As a result, there was no medical diagnosis of throat cancer. He had seen a doctor for chronic laryngitis, and when that condition became severe the doctor recommended he see a specialist, but he did not do so.

In considering whether the veteran died from malignant neoplasm of the larynx, the AAT had regard to the symptoms as described by Mrs Green and other witnesses and to textbooks and a reputable website (www.intelihealth.com) describing the symptoms of that disease. The AAT said:

[29] Although Mrs Green did not use the terminology used in the medical authorities, it is abundantly clear that the symptoms which she described are all symptoms of throat cancer. …

[30] … Dr Morgan agreed that the symptoms described by Mrs Green are consistent with throat cancer. However, he also said that the symptoms are consistent with other chronic laryngeal conditions such as non-malignant tumours (eg, laryngeal nodules and squamous papillomas) and chronic infections such as TB and Candida. …

[31] That, however, does not end the matter. I have also examined information obtained from the internet site of CancerHelp UK regarding non-cancerous growths in the voice box and the Cornell University site dealing with laryngeal papillomatosis, vocal nodules and laryngitis. All of these conditions have smoking as one of the possible causes. No SoP exists for these diseases … As for chronic infections such as TB and Candida, the symptoms which are described on the InteliHealth website do not match the symptoms so graphically described by Mrs Green I have therefore formed the view that these infections … are unlikely to have been the cause of Mr Green's problem.

[32] I have also considered s 119(1)(h) of the VE Act. That requires the Commission to take into account any difficulties that, for any reason, lie in the way of ascertaining the existence of any fact, matter, cause or circumstance, including any reason attributable to the effects of the passage of time, including the effect of the passage of time on the availability of witnesses and the absence of or a deficiency in relevant official records. …

[33] Despite the lack of medical records, the symptoms described by Mrs Green in her own words bear such a close resemblance to those described in the medical authorities to which I have referred that I have come to the conclusion, on the balance of probabilities, that Mr Green did suffer from a severe laryngeal condition immediately before his suicide.

[34] Quite clearly this is a most difficult and unusual case. The difficulty arises because Mr and Mrs Green were unable to either seek a diagnosis or proper medical treatment. … The Commission conceded that if I were to find that Mr Green did suffer from a malignant neoplasm of the larynx, then it would concede that Mr Green had a war-caused smoking habit sufficient to meet the SoP factor for malignant neoplasm of the larynx. Even if Mr Green suffered from another form of chronic laryngeal disease, … because there is no SoP in existence for those diseases, … it is open to me to find that, on the balance of probabilities, Mr Green suffered from a severe illness which was smoking related. This would satisfy a reasonable hypothesis connecting Mr Green's illness with his war service. It follows, in my opinion, given that the sub-hypotheses support the hypothesis linking Mr Green's death with his operational service, the hypothesis must be reasonable. In the circumstances, I cannot be satisfied beyond reasonable doubt that there is no sufficient ground for determining that Mr Green's death was war-caused.

Formal decision

The AAT set aside the decision under review and found Mr Green's death was war-caused.

Re Streatfield and Repatriation Commission

Shearer, Senior Member
Campbell, Member

[2006] AATA 185
1 March 2006

Reasonable hypothesis – kind of death – pedestrian killed by motor vehicle

Mr Streatfield was killed in 1976 when he was struck by a passing motor vehicle as he was standing by the roadside. Mrs Streatfield contended that a head injury he suffered during his service caused him to develop serious headaches and dizziness, which led to him falling in front of the vehicle.

Mr Streatfield rendered operational service in the Army in World War 2. While in a training exercise he ran into a clothes line and was rendered unconscious. He was hospitalised, and was noted to be somewhat confused and amnesic. During service he also suffered from dengue and dermatitis. He was treated for malaria in 1946-47. Mrs Streatfield said that he suffered bouts of malaria after service which would be accompanied by dizziness and nausea, and for which he took Bex or Vincents painkilling tablets.

There was no medical evidence concerning the veteran's headaches, but Mrs Streatfield gave evidence that:

> … he would rarely speak about the pain of his headaches and he refused to see a doctor. … Not long before he died [he] was getting headaches very frequently and his head even started to shake ever so slightly during these times as well.

A neurologist gave evidence that headaches persist in about 20% of patients who suffer head injuries involving post-traumatic amnesia of up to four days.

The AAT set out the evidence from the Coroner's inquiry:

> [10] … Evidence before the Coroner showed that the Veteran had been standing beside the roadway on Parramatta Road Haberfield, apparently intending to cross to the other side … . He had earlier parked his car in a side street. It was at about 6 pm, that is, at about sunset. The place where he had been standing was well lit. Parramatta Road is a busy road, and at that hour is a clearway. Traffic was heavy and moving fast, including in the lane immediately adjacent to the kerbside. The Veteran was standing behind a telegraph pole, and he may on that account not have been visible to oncoming traffic. There was no pedestrian crossing at the point where the Veteran was standing. The Veteran was struck by an oncoming van, and was thrown by the impact backwards about 15 feet on to the concrete footpath, sustaining a fatal head injury. The protruding rear vision mirror of the van … was subsequently found to be severely bent out of position. … Three possible explanations of the accident were considered by the Coroner:
>
> (a) the Veteran had stepped off the footpath into the path of the van;
>
> (b) the Veteran had slipped on the downward sloping grass verge between the footpath and the gutter edge into the path of the van;

(c) the Veteran was still standing on the gutter edge when he was struck by the protruding rear vision mirror of the van.

[11] Of these three explanations the Coroner regarded the first as the least likely, but he declined to make a formal finding of the cause of the accident.

[12] The post mortem examination of the Veteran revealed no alcohol in the blood. The cause of death was stated to be fractured skull and brain injury.

The AAT considered the 'kind of death' suffered by the veteran. While it had been suggested that it could have been death from skull fracture, or death from migraine, the AAT found it to be death from brain injuries. The AAT then discussed whether a reasonable hypothesis had been raised by the material. It said:

[36] In *Repatriation Commission v Bey* (1997) 79 FCR 364, the Full Court of the Federal Court held that:

> A 'reasonable hypothesis' involves more than a mere possibility. It is a hypothesis pointed to by the facts, even though not proved upon the balance of probabilities.

[38] Did the Veteran suffer frequent headaches? And was he prone to headaches at or about the time of his death? The material before the Tribunal points to an affirmative answer to both questions, on the basis of the Applicant's evidence.

[39] A third question is raised: was there material before the Tribunal pointing to a disposition of the Veteran, at or around the time of his death, to have headaches of a degree that led to behavioural consequences such as stumbling or loss of balance? No such material was put before the Tribunal.

[40] Is a reasonable hypothesis raised by the whole of the material before the Tribunal that the headaches suffered by the Veteran were connected with war-service? The evidence of Professor Corbett was argued to support this hypothesis, although he agreed at the hearing that it was difficult to separate possibility from mere speculation. Professor Lance, by contrast, was of the opinion that the migraine headaches began in the 1950s and not during war service. However, he did state that the hypothesis that they started during war service was possible, although in his view not probable.

[41] Even accepting that the Veteran's recurrent headaches amounting to migraine were war-caused, the crucial part of the hypothesis to be substantiated is that there is material pointing to the headaches having been present at the moment of the Veteran's being struck by a vehicle and as having played a part in that event. On that question there is no material whatsoever pointing to the Veteran's war-caused headaches having contributed to his death; there is merely speculation. For that reason the hypothesis cannot be considered reasonable.

Formal decision

The AAT affirmed the decision under review.

Editor: While there was material to raise a hypothesis of a connection to service, it was not 'reasonable'. The evidence did not point to an essential part of the suggested chain of causation.

Re Parker and Military Rehabilitation and Compensation

McCabe, Senior Member

[2006] AATA 440
23 May 2006

Unintended consequence of medical treatment

This case was decided under s 6A of the *Safety, Rehabilitation and Compensation Act 1988* (SRCA). As noted in the article at page 38, that section is similar in effect to s 29 of the *Military Rehabilitation and Compensation Act 2004*.

Mr Parker suffered from a right retinal vein occlusion, which is an interruption to the blood flow to the retinal cells of the right eye. It was recommended that he undergo a surgical procedure called a chorioretinal laser shunt.

The ophthalmic surgeon gave evidence that the procedure was successful in only 30-40% of cases and there was risk of significant complications. However, he explained he was hopeful the procedure would save what vision the applicant had left, or perhaps even result in an improvement. He said there was no alternative if the eye was to be saved.

Another specialist gave similar evidence but said that most of the people who were not assisted by the procedure would not in any event be hurt by it. He suggested the prospect of serious complications was as low as 5-10%.

Mr Parker underwent the shunt procedure at Commonwealth expense under reg. 58F of the Defence Force Regulations.

On follow up, the surgeon was found that Mr Parker had suffered a major vitreous haemorrhage and fibrovascular proliferation (the growth of new blood vessels and fibrous tissue around the site of the shunt). This required a vitrectomy (removal of the jelly inside the eyeball) and laser photocoagulation to remove the new blood vessels that had developed.

This procedure did not work, and Mr Parker became blind in his right eye.

The AAT noted that it had to look to the intentions or objectives of the doctor and ask whether the injury in question was a likely consequence of that treatment, referring to *Re Eaton and Comcare* (2002) 67 ALD 182 at 194; and *Re Shoobert and MRCC* [2004] AATA 1087 at [30].

The MRCC conceded that the surgeon did not aim for, or design, the fibrovascular proliferation that focused on the shunt site, and did not intend there to be damage to the retina. The AAT then considered whether this was a likely result of the procedure, and said:

> [35] It may be that fibrovascular proliferation was an unavoidable consequence of the procedure. Dr Ambler in particular says it is a natural reaction to ischaemic change. But whether or not fibrovascular proliferation could be characterised as an injury for the purposes of s 6A, it is not the injury in question here. Dr Ambler clearly did not think it was likely that the retinal damage following the fibrovascular proliferation would occur. While he agreed the success rate of the procedure was not high, he said

he believed the damage Mr Parker suffered occurred in a much smaller number of cases. All of the medical experts agreed damage to the retina was a known complication, but the consensus appeared to be that it occurred in only 5-10% of cases.

[36] The word 'likely' is used in a number of statutes, and its use in those contexts has been considered in a number of cases. [Counsel for the MRCC] referred me to some of them in his outline of argument. I think one should treat those cases with caution because I am not interpreting the word 'likely' in the context of a statute. Suffice to say I am satisfied a risk that something might occur in 5-10% of cases does not mean the event is likely to occur.

[37] I accept there is a causal connection between the procedure and the injury I have identified. I acknowledge the applicant may have gone blind even if he did not have the procedure. I do not think that matters. The requirements of s 6A are satisfied.

Permanent Impairment

[38] Once liability has been accepted under s 14, it remains to be seen what (if any) compensation must be paid. The applicant has asked for compensation in respect of permanent impairment pursuant to s 24. It is clear the applicant has experienced a permanent impairment, ie blindness in the right eye.

[39] The respondent is required to assess the amount of the impairment according to Comcare's *Guide to the Assessment of the Degree of Permanent Impairment*: s 28(4). [Counsel for the MRCC] referred in his written submissions to the discussion of the concept of aggravation. The discussion suggested that where the impairment would have resulted from the natural progression of the condition that was unrelated to employment, the assessment of the degree of permanent impairment should be nil. [The MRCC]'s argument amounts to this: if the blindness was bound to occur in any case, the failure of the surgery attempted in a last-ditch attempt to stave off those consequences should not make the Commonwealth liable for blindness.

[40] I think [the MRCC] is right. Here, the evidence from Dr Ambler in particular suggests the only hope of saving the applicant's eye-sight was the surgical procedure. The procedure did not work. Complications associated with the procedure resulted in damage to the retina that led to blindness. That explains why the applicant went blind when he did. But given the applicant was likely to go blind in any case at some point in the future because of his underlying condition, the applicant has not suffered any permanent impairment as a result of the surgery. The same can be said of a claim that the applicant has suffered a permanent impairment in the form of a facial disfigurement. He was likely to suffer from such a condition in any event.

Formal decision

The AAT set aside the decision under review and found the MRCC was liable for compensation for the right eye injury, but it was not liable to pay compensation in respect of permanent impairment under the SRCA.

Editor: See the article at page 38.

Federal Court of Australia

Repatriation Commission v Constable

Spender, Weinberg, Edmonds JJ
[2006] FCAFC 102
26 June 2006

Alcohol dependence or abuse Statements of Principles – ‘experiencing a severe stressor’

Mr Constable’s claim for alcohol dependence or abuse was based on observing ‘casualty clearance’ in Vietnam when he saw a Landrover drive past him containing 3 wounded troops with bloodied bandages.

The relevant Statement of Principles factor provides:

> (b) experiencing a severe stressor within the two years immediately before the clinical onset of alcohol dependence or alcohol abuse …

The expression ‘experiencing a severe stressor’ is defined in clause 8 of the SoP to mean that:

> ... the person experienced, witnessed or was confronted with, an event or events that involved actual or threat of death or serious injury, or a threat to the person’s or other people’s physical integrity, which event or events might evoke intense fear, helplessness or horror.
>
> In the setting of service in the Defence Forces, or other service where the Veterans’ Entitlements Act applies, events that qualify as severe stressors include:
>
> (i) threat of serious injury or death; or
>
> (ii) engagement with the enemy; or
>
> (iii) witnessing casualties or participation in or observation of casualty clearance, atrocities or abusive violence ...

It was not contested, and the Full Court agreed with the Judge at first instance in *Constable’s* case (Dowsett J), that the AAT was wrong when it said:

> … the [Statement of Principles] requires that the person experienced an event that involved actual or threatened death or serious injury. The definition contemplates, in the Tribunal’s view, that there is an immediacy of exposure to the event. Here the casualties were being transported to hospital and this is several steps removed from the threat envisaged in the definition.

The Court held that there was no requirement of immediacy of exposure to the event that caused the casualties.

The Commission’s appeal concerned the proper test to be applied when determining whether an event is one that ‘might evoke intense fear, helplessness or horror’. Dowsett J had said:

> [26] … The question was not whether a reasonable person of the same rank and experience as the applicant would have experienced intense fear, helplessness or horror. The question was simply whether or not the applicant had identified an event which might have evoked such a reaction.

Dowsett J had also indicated (at para [23]) that the phrase 'might evoke … invites examination of the event itself rather than its effect upon the applicant.' The Full Court rejected such an approach, saying:

> [38] The reasons of the primary judge seem to suggest that there is no subjective element in the requirement of 'experiencing a severe stressor', and the examination of the event has to be assessed entirely objectively. That approach is inconsistent with the reasons for judgment of two Full Courts; the first in *Repatriation Commission v Stoddart* (2003) 77 ALD 67 affirming the decision of Mansfield J at first instance in *Stoddart v Repatriation Commission* (2003) 74 ALD 366, and *Woodward v Repatriation Commission* (2003) 75 ALD 420, particularly at 439-440.

The Full Court then discussed possible interpretations of the effect of the examples in subparagraphs (i), (ii), and (iii) in the definition in clause 8 of the SoP on the meaning of 'experiencing a severe stressor'. The Court appears to have concluded that the better interpretation is that experiencing any of the circumstances set out in subparagraphs (i), (ii) and (iii) in the definition will qualify as 'experiencing a severe stressor' whether or not they might evoke intense fear, helplessness or horror. The wording of the introductory words to those subparagraphs indicates that such events 'qualify as severe stressors' for the purpose of the definition, and so act as a deeming provision. The clause did not say '*might* qualify', but simply 'qualify'.

Editor's comments:

In relation to a claim of witnessing casualties or casualty clearance, the SoP does not require that the event that caused the casualties be close in time to when the casualties or casualty clearance is observed.

If the evidence points to (for reasonable hypothesis cases) or demonstrates (for balance of probabilities cases) that the veteran or member experienced an event set out in any of subparagraphs (i), (ii), or (iii) of the definition of 'experiencing a severe stressor' in the SoP for alcohol dependence or abuse such an event will meet the definition whether o not it 'might evoke intense fear, helplessness or horror'.

However, for cases in which the evidence points to or demonstrates that the veteran or member experienced other kinds of events *not* listed in those paragraphs, the evidence would need to point to or demonstrate that the event 'might evoke intense fear, helplessness or horror'. This is a combined subjective and objective test similar to the test in *Stoddart's* and *Woodward's* cases: it must be 'judged objectively from the point of view of a reasonable person in the position of the applicant experiencing it' to decide whether it 'was capable of conveying, and did convey' feelings of intense fear, helplessness or horror.

The SoP's use of the word 'includes' before subparagraphs (i), (ii), and (ii) may create a difficulty in this approach. One cannot be sure which events will qualify as experiencing a severe stressor without having to meet the 'might evoke intense fear, helplessness or horror' test.

Repatriation Commission v Butcher

Besanko J
[2006] FCA 811
30 June 2006

Special rate – meaning of 'remunerative work that the veteran was undertaking'

Mr Butcher served in the Army from 1974 until 1981. After discharge, he worked for relatively short periods as a truck driver, fork-lift driver, storeman, process worker, labourer and general hand. He was unemployed for various periods and has now ceased work. He was in receipt of disability pension at 100% of the general rate, relating to various psychiatric disorders as well as hypertension and psoriasis. That assessment was appealed to the AAT.

His accepted disabilities involve symptoms of anxiety, panic attacks, constant edginess, psoriasis affecting every part of his body preventing him working in hot or closed environments, or environments where he would be exposed to dirt, dust or chemicals. His psoriasis is exacerbated by psychological stress.

Mr Butcher last worked in 1998 as a general hand for Comit Farm, in the field and in processing sheds. This was manual work, which was quite dirty. He left that work because of his skin psoriasis and anxiety disorder.

After leaving that work, he has developed a non-accepted disability relating to his cervical spine. The AAT found that this disability would prevent him doing some of the kinds of work he had previously undertaken, such as labouring in tasks that involved working above his head and looking up or down for long periods, such as fixing ceilings or painting, concrete laying, flooring, or fork-lift driving. It found that it would not prevent him undertaking work as a storeman, general farm labourer, or truck driver.

The AAT found that his accepted disabilities alone prevented him from continuing to engage in the kind of work he had undertaken at Comit Farm, and that he had ceased to engage in work for no other reason than his accepted disabilities. It assessed pension at the special rate from August 2004.

The Commission appealed on the ground that as the AAT had characterised the remunerative work Mr Butcher had been undertaking as truck driver, fork-lift driver, storeman, process worker, labourer and general hand, and it had found that his non-accepted disability prevented him doing some of those types of jobs, the requirements of s 24(1)(c) were not met. The Commission argued that Mr Butcher had to be prevented by accepted disabilities alone from continuing to undertake ***all*** the kinds of work he had been undertaking, not just some of them.

Counsel for Mr Butcher argued that the AAT had merely identified all the different kinds of work Mr Butcher had ever done, but that this was not characterisation of remunerative work for the purpose of s 24(1)(c). It was argued that when the AAT considered

s 24(1)(c), it referred to his work as a storeman, general farm labourer or truck driver.

The Court found that the AAT had made either one of two errors, either it had:

- characterised the remunerative work Mr Butcher was undertaking as all six forms of work but then applied s 24(1)(c) to some only of these forms; or
- it incorrectly approached the process of characterisation of the remunerative work Mr Butcher was undertaking for the purposes of s 24(1)(c).

The Court was unable to identify which error the AAT had made from the AAT's reasons, but said that, either error would require the Court to intervene.

In relation to the first error, the Court did not explain it other than to say that:

> 'the error lies in selecting without explanation some only of six specific forms of employment as the remunerative work the respondent was undertaking for the purposes of the subsection.'

In relation to the second error, the Court noted that Mr Butcher's case required the AAT to give a more general characterisation of remunerative work than had been given.

The Repatriation Commission had asked the Court to proceed to decide the matter rather than remit it to the AAT, and so the Court explained what it meant by the second error of law in deciding the case itself.

The Court noted that the findings of primary fact were not in dispute, but that the nature of the remunerative work Mr Butcher was undertaking needed to be reconsidered. The Court set out Mr Butcher's working history since discharge as follows:

Period	Position	Employed
November 1983 – June 1985	Process worker	Stan Bond Limited
December 1985 – ?	Yard hand	North East Timbers
August 1988 – February 1989	Truck driver	MRW Co-op
August 1989 – ?	Truck driver	Linfox Transport Australia Ltd
March – May 1992	Fork-lift driver	Adelaide Steel Processing
March – May 1998	General hand	Comit Farm Produce Pty Ltd

The Court noted that:

> [37] First, it is not a matter of focusing on the last job the veteran had, or indeed, any particular job; rather, the phrase 'remunerative work that the veteran was undertaking' refers to the type of work the veteran was undertaking or his field of activity …
>
> [38] Secondly …, the issue requires the decision maker to identify the 'substantive remunerative work' that the veteran has undertaken in the past …, or the 'substantial remunerative work that he has undertaken in the past'. … Thirdly, … the appropriateness of any particular description of work that has been undertaken is governed by the purpose of the description, and in cases under s 24(1)(c), that purpose is one related to capacity to work.
>
> …
>
> [42] It seems to me that the determination of the type of work the veteran was undertaking, or his or her

field of activity, involves a consideration of the veteran's qualifications and the work which he or she has in fact undertaken in the past. On occasions, the decision will be a relatively straightforward one, where, for example, the veteran has specialised qualifications and has only ever worked in one field of employment. In other cases, of which this is one, the decision will involve a process of characterisation and is not necessarily resolved by simply characterising the field of remunerative activity as involving all of the particular types of employment which the veteran has undertaken. Nor will it necessarily be appropriate to include in the field of activity a particular type of employment performed some time in the past for a short period of time.

[43] The decision as to the characterisation of the type of work the veteran was undertaking is, like the decision as to causation, a decision which must be made with an eye to reality, and as a matter in respect of which common sense is the proper guide. An unduly narrow definition may result in veterans receiving the pension at the special rate in circumstances not contemplated by the legislation. An unduly wide definition may result in veterans being refused the pension at the special rate in circumstances in which, in reality, they are not working (and thereby not receiving wages) solely because of war-caused injuries or diseases. In other words, the danger in the case of an unduly wide definition is that a veteran will be denied the pension at the special rate in circumstances where, in reality, it is very unlikely that even without any injuries or diseases, the veteran would ever have undertaken a particular form of employment which happens to fall within the wide definition.

[44] In my opinion, in this case a more general characterisation of the type of work, or field of remunerative activity, [Mr Butcher] was undertaking is appropriate, rather than the one which includes all six previous forms of employment. I would describe the remunerative work [Mr Butcher] was undertaking as general labouring duties involving unskilled work, process work and general driving duties. I would not include driving a fork-lift in the description of general driving duties. That was employment he undertook for only a short period of time and the question is the 'substantive' or 'substantial' remunerative work [Mr Butcher] has undertaken in the past. That leaves for consideration whether, in this case, the general labouring duties involving unskilled work includes tasks that required work above his head, such as fixing ceilings or cornices, or painting, or prolonged looking down such as concrete laying or flooring work. I do not think that it does, because there is no evidence that [Mr Butcher] undertook such work on a prolonged or repetitive basis for any period of time, or that he was qualified to undertake such work.

The Court found that Mr Butcher's non-accepted cervical spine condition would not have prevented him from continuing the remunerative work he was undertaking. It also rejected a suggestion that Mr Butcher's age and lack of recent work experience were significant enough

for the AAT to have erred in law in failing to mentioned them as disentitling factors. The Court thus upheld the AAT's decision to assess pension at the special rate, but for different reasons.

The appeal was dismissed with costs awarded to Mr Butcher.

The Court was permitted to make findings of fact and proceed to determine this matter because of an amendment of s 44 of the *Administrative Appeals Tribunal Act 1975* by Act No. 38 of 2005. New subsections 44(7) to (10) permit the Court to make findings of fact not inconsistent with findings made by the AAT (other than findings made by the AAT as the result of an error of law). Without this amendment, it is possible that, having found the AAT had made a legal error, the Court would have remitted the matter to the AAT to be reheard and would have awarded costs to the Commission rather than to Mr Butcher. Being now able to determine the matter itself, the Court found that the outcome of the AAT case was not affected by the legal error, and so the appeal was dismissed.

Editor's comments:

The Court did not mention *Repatriation Commission v Graham* [2004] FCA 1287 (2004) 20 *VeRBosity* 136. In *Graham*, the Federal Court found there was no error in the AAT characterising Mr Graham's work in managing holiday units as involving two separate kinds of remunerative work (gardener and motel manager), only one of which he was prevented from continuing to undertake by reason of war-caused disabilities alone. Mr Graham's assessment at the special rate was upheld on that basis.

***Butcher's* case appears to suggest that a more general characterisation of work is required in that it speaks of needing to identify 'the' substantive remunerative work or 'the' substantial work that the person has undertaken in the past (paragraph [38]), rather than any substantive or substantial remunerative work the person undertook.**

However, as *Graham's* case has not yet been overruled and the phrase '*the* remunerative work' is not included in s 24(1)(c), *Butcher's* case should probably be considered in light of, and interpreted consistently with, *Graham's* case. In trying to reconcile these two cases in looking at s 24(1)(c), it is not a matter of characterising the overall work that a person was undertaking at a particular point in time, but it is necessary to characterise the distinct kinds of work undertaken that were substantive and substantial.

Every case requires a careful analysis of the person's work history to decide whether the person was undertaking

one or more kinds of remunerative work.

As Besanko J recognised, the breadth of that characterisation may be very important in deciding whether the special rate criteria are satisfied.

On a broad characterisation of Mr Graham's work in managing holiday units (as was argued by the Repatriation Commission in that case), he might not have been able to succeed, whereas, a narrower characterisation enabled him to do so.

The question of whether the relevant kind of remunerative work that the person was undertaking was 'substantive' or 'substantial' will always be an important factor to consider.

The words 'substantive' and 'substantial' do not appear in the text of the section, but were used in *Hendy's* case [2002] FCAFC 424, (2002) 18 *VeRBosity* 115 and *Starcevich's* case (1987) 3 *VeRBosity* 163, respectively, to describe the 'remunerative work' referred to in s 24(1)(c) that the veteran was prevented from continuing to undertake by incapacity from war-caused injury or disease alone.

The word, 'substantive', in *Hendy's* case appears to have been used in the same sense that the word, 'substantial', was used in *Starcevich's* case. *Butcher's* case appears to indicate that these words might have different shades of meaning. Perhaps, in the context of s 24(1)(c), it might be said that:

- 'substantive remunerative work' indicates that the kind of remunerative work has a separate and independent existence to other remunerative work undertaken by the person;
- 'substantial remunerative work' indicates that the kind of remunerative work is of real importance and value to the person as well as being undertaken over an extended period and for a number of hours per week.

It remains to be seen whether such a distinction develops in the case law on s 24(1)(c).

Paterson v Repatriation Commission

Heerey J
[2006] FCA 538
12 May 2006

Reasonable hypothesis – Deledio steps – no fact-finding at step 3

The Tribunal considered three hypotheses that were said to connect Mr Patterson's hypertension with his operational service. These were that the circumstances of his operational war service in Vietnam led to:

1. an increased consumption of alcohol and/or snack foods and/or salty foods, which consumption continued due to taste, preference and habit, and which contributed to weight increase and obesity, which contributed to the onset of hypertension (***the obesity hypothesis***); and/or
2. an increased consumption of alcohol which contributed to the onset of hypertension (***the alcohol hypothesis***); and/or
3. an increased consumption of salt which contributed to the onset of hypertension (***the salt hypothesis***).

The Tribunal had found that the obesity hypothesis was reasonable, but that it was disproved beyond reasonable doubt. It found that the alcohol and salt hypotheses were not reasonable because they were not upheld by the SoP.

In its consideration, the Tribunal recited the *Deledio* steps, which provided that there is no fact-finding at step 1 and that the only step at which facts are to be found is at step 4. The Tribunal said:

> [43] In respect of the third step from *Deledio*, in relation to factor 5(b) of the SoP, the Tribunal takes into account the estimates given by the applicant, in Exhibit 6, of his alcohol consumption in 1978. The Tribunal takes into account the evidence from Dr Strauss, who described the applicant's alcohol consumption before and after service and concluded that the applicant was not a heavy drinker, and that the applicant's post-service consumption was mainly beer consumed with counter lunches once or twice per week and in the evenings. The Tribunal also notes Dr English's evidence that the applicant did not provide dietary intake data to substantiate his claim that he consumed 200 gm of alcohol per week in 1978, and her comments that he has not completed an alcohol questionnaire to substantiate his claim. The Tribunal further notes the applicant's evidence that after Vietnam his alcohol consumption increased. The Tribunal finally notes that the applicant told Dr Strauss that after leaving the army his alcohol consumption was never an issue for him or those around him.
>
> [44] The Tribunal accepts the submission from Ms McCulloch [counsel for the Commission] that the estimates provided by the applicant in Exhibit A6 are unreliable and are not supported by objective evidence. For these reasons the Tribunal concludes that the applicant was not consuming at least 200 gm (20 standard drinks) per week on average at the time of the clinical onset of hypertension in 1978. As a result there is no material or evidence pointing to the hypothesis being a reasonable one, and it is not consistent

with the template in the SoP concerning hypertension (*Hill*). Therefore, the applicant does not satisfy the third step from *Deledio* in relation to factor 5(b).

[45] In respect of the third step from *Deledio*, in relation to factor 5(c) of the SoP, the Tribunal takes into account the estimates given by the applicant in Exhibit A6 and the assumptions underlying the figures provided by him, and the research conducted by Dr Kennedy (sic) and the James study about salt ingestion, plus research cited by Dr English. The Tribunal accepts Ms McCulloch's submission that the term salt supplements as defined in the SoP is confined to salt added to food when cooking or eating, and salt tablets. On this basis the Tribunal does not accept that salt used in packaged snack foods fits within the definition.

[46] The Tribunal agrees with Ms McCulloch that the estimates of his salt consumption by the applicant are speculative. The Tribunal also agrees that the figures given in Exhibit A6, as a re-construction of events that took place many years ago, are unreliable and inaccurate, and the amounts listed for salt contained in potato chips, Twisties and soy sauce should be disregarded. For these reasons the Tribunal finds that the applicant did not ingest at least 12 gm of salt supplements per day on average, at least 6 months immediately before the clinical onset of hypertension. In the circumstances there is no material or evidence pointing to the hypothesis being a reasonable one, and it is not consistent with the template in the SoP concerning hypertension (*Hill*). The applicant does not satisfy the third step from *Deledio* in relation to factor 5(c) of the SoP.

The Court criticised the Tribunal's approach in relation to the alcohol hypothesis, saying:

> [38] The third *Deledio* step does not require or permit fact finding, an exercise which is confined to the fourth step. Yet it is clear this is what the Tribunal did at [43] and [44]. The reference to Dr English's criticism of 'lack of dietary intake data' suggests not only fact finding but the imposition of an onus of proof on Mr Patterson, something excluded by s 120(6). The Tribunal reached a conclusion as to what in fact Mr Patterson's alcohol consumption was rather than enquiring whether his hypothesis was consistent with the SoP.

In relation to the salt hypothesis, the court said:

> [40] Much the same thing happened with the salt hypothesis. The Tribunal made a qualitative assessment of Mr Patterson's evidence and accepted criticism of it as 'speculative', 'unreliable' and 'inaccurate'. This is the discourse of fact finding.
>
> [41] If the Act, like most statutes conferring pensions and similar benefits, simply required Mr Patterson to establish that his hypertension was due to war service, then the Tribunal's approach would disclose no error of law. However, for the historical and political reasons which underlie repatriation legislation in Australia, as discussed in *Deledio* and *East v Repatriation Commission* (1987) 16 FCR 517, the Act mandates a unique decision-making process. The Tribunal failed to apply that process.

It should be noted that, in relation to the obesity hypothesis, the Court found that

the Tribunal's decision could not be impugned. The tribunal had not engaged in fact-finding until the 4th step. The Court said:

> [37] … the Tribunal understood its task at that stage, the fourth of the four-step *Deledio* process. It engaged in an assessment of the evidence and reached a conclusion that the connection between obesity and war service was disproved beyond reasonable doubt. Whether this Court would have reached the same conclusion is not to the point. No error of law is shown.

The Court allowed the appeal, set aside the AAT's decision and ordered the matter to be reheard. Costs were awarded to Mr Patterson.

Editor's comments:

In cases to which the reasonable hypothesis provisions apply, decision-makers must be careful not to make findings of fact *except* when deciding:

- **the nature and extent of the veteran's or member's eligible service (*balance of probabilities*) – preliminary step;**
- **the kind of injury, disease or death to which the claim relates (*balance of probabilities*) – preliminary step;**
- **whether the claimant is a person who can make the claim (*balance of probabilities*) – preliminary step;**
- **whether a fact inconsistent with the hypothesis has been proved (*beyond reasonable doubt*) – *Deledio* step 4;**

whether a fact necessary for the hypothesis has been disproved (*beyond reasonable doubt*) – *Deledio* step 4.

Leigh v Repatriation Commission

Dowsett J
[2006] FCA 395
12 April 2006

Special rate of pension – whether incapacity for remunerative work is temporary or permanent – meaning of 'permanent'

Mr Leigh was born on 7 May 1980. He served in East Timor from 20 September 1999 to 19 February 2000 and from October 2001 to April 2002. The following conditions were accepted as war-caused:

- post traumatic stress disorder;
- alcohol dependence or abuse; and
- sensorineural hearing loss and tinnitus of the right ear.

The Repatriation Commission assessed pension at the temporary special rate with effect with effect from 11 December 2003 and until 11 December 2005. On 25 August 2004 the Board varied that decision by determining that the special rate should continue until 25 August 2009.

Mr Leigh applied for review to the AAT, arguing that his incapacity for work was permanent, not temporary. The AAT affirmed the Board's decision, and Mr Leigh appealed to the Federal Court.

At the AAT hearing evidence from Mr Leigh's treating psychiatrist, Dr Rogers, was that:

> … his incapacity is likely to continue for an indefinite period given the above experience. It should be noted that

> permanence does not refer to a condition incapable of responding to treatment at some stage but certainly one that is static and constant and likely to persist for an indefinite period in the future.

Dr Rogers predicted that if Mr Leigh were re-assessed in four years time there would not be any substantial improvement in his condition.

Dr Cook, a psychiatrist who gave evidence at the request of the Commission, gave evidence that:

> At the present time he cannot work even for eight hours per week, and I do not see that improving in the short term. However the possibility of improvement still exists and, in my opinion, there is an approximate 50% chance that Mr Leigh will be able to re-enter the work force over the next four or five years, even if it is within a limited/part time capacity.

Dr Cook did not accept that Mr Leigh was permanently incapacitated having regard to his age and other positive aspects of his background. Dr Cook considered that there were prospects of some significant improvement. However, he accepted that permanent incapacity was a possibility.

The AAT considered the Federal Court judgment in *McDonald v Director General of Social Security* (1984) 6 ALD 6 at 13, which dealt with the concept of 'permanent incapacity' in the *Social Security Act 1947*. In that case Woodward J said:

> The vital contrast between temporary and permanent incapacity must be based upon an assessment of future prospects at the time the decision is made. It is not inconsistent with the notion of permanent incapacity that the pensioner's position should be reviewed from time to time. Unexpected improvements in the person's condition, advances in medical science, the achievement of fresh skills, or even changes in the labour market, could bring to an end an incapacity which had been thought to be permanent.
>
> In my view the true test of a permanent, as distinct from temporary, incapacity is whether in the light of the available evidence, it is more likely than not that the incapacity will persist in the foreseeable future ...
>
> This test involves two questions. The first is whether it is more likely than not that the disability will terminate (or fall below 85% in the sense – referred to above) at some time in the future. Even if the answer to this question is 'yes' I think it would be inaccurate in the context of employment to describe as 'temporary' a condition which was likely to last for a number of years. Hence the two elements of degree of likelihood of improvement and time span for that improvement, should be weighed together in determining what is permanent and what is temporary. The greater the likelihood of substantial improvement and the earlier that it is likely to occur, the more accurate will be a 'temporary' label. The longer the period and the less probable the improvement, the more appropriate will be a finding of permanent incapacity ...'

The AAT, in discussing this case, indicated that this approach was not applicable to the question posed by s

24(1)(b) of the VEA. The AAT placed some emphasis on the phrase 'never go back to work' as used by the Minister in the Second Reading Speech to the special rate amendments in 1985.

The Federal Court said that the observations made by Woodward J in *McDonald's* case may well be applicable to s 24(1)(b) of the VEA, but that the AAT's decision could not be impugned merely if the AAT had wrongly said that a statement from a judgment relating to other legislation was inapplicable. The Court had to consider how the AAT had, in fact, applied the section to the facts of Mr Leigh's case. The Court noted that the AAT had concluded that the word, 'permanent', as used in s 24 meant 'for a period longer than just a few years hence', and that this implied that a demonstrated incapacity for a few years would not, at least in Mr Leigh's case, be a basis for assessing pension at the special rate under s 24.

The Court said that it was open to the AAT to prefer the evidence of Dr Cook that there was a 50% chance that Mr Leigh would be able to re-enter the workforce over the next four or five years, although in a limited or part-time capacity, exceeding 8 hours per week.

Formal decision

The Court dismissed the appeal and awarded costs to the Repatriation Commission.

Editor's comments:

The notion of permanence in s 24(1)(b) must be considered in light of the particular circumstances of each case. A rule cannot be set to say that 2, 3, or 4 years of foreseeable incapacity indicates permanence.

The person's age, resilience, and capacity for treatment or rehabilitation may be important factors to be weighed in assessing the permanence of a particular incapacity.

Nevertheless, care needs to be taken that these factors are considered only for the purpose of assessing permanence of incapacity, and not for assessing whether a person is incapable of undertaking remunerative work.

Section 28 sets out the only matters relevant for assessing whether a person is incapable of undertaking remunerative work, but it does not govern the question of the permanence or otherwise of such incapacity.

Federal Magistrates Court of Australia

Repatriation Commission v Richardson

Jarrett FM
[2006] FMCA 478
6 April 2006

Reasonable hypothesis – post traumatic stress disorder – depressive disorder – alcohol abuse – AV* Clive Steele *in Vietnam – nature of the evidence required to raise or disprove a reasonable hypothesis

Mr Richardson claimed that his post traumatic stress disorder, depressive disorder, and alcohol abuse were related to his service aboard the Army Vessel *Clive Steele* in Vietnam.

Mr Richardson gave evidence at the AAT that on 17 February 1967 he was required to fire a Bofors gun to provide harassment and interdictory fire on a hill above a civilian compound.

He was concerned that he missed the target and had hit the civilian compound. He said that when he went to investigate the next day, he saw dead bodies and heard women and children scream. He reported this to the Captain, who told him that nothing had happened and not to talk about it. He then went to the mess, drank alcohol, and did not tell anyone else about it.

The AAT noted that there was medical evidence supporting a causal link between the incident as described by Mr Richardson and his post traumatic stress disorder, depressive disorder, and alcohol abuse, and found the hypothesis connecting the events as described by Mr Richardson and his claimed disabilities was raised and was reasonable.

The AAT then considered the fourth *Deledio* step (deciding whether the hypothesis is disproved beyond reasonable doubt) and examined the evidence of:

- the gunnery sergeant in AV *Clive Steele*, who said that the gun did not fire on the civilian compound;
- a detailed diary of a medical practitioner who was in the compound in the relevant period, who made no mention of this event yet mentioned a bus crash; and
- the ship's log, which mentioned the firing of practice rounds, but nothing else of consequence.

The AAT also noted some discrepancies in Mr Richardson's evidence that were pointed to by the Commission, but decided that no facts that had been raised by the material and which were necessary for the hypothesis, had been disproved beyond reasonable doubt. The AAT set aside the decision under review and found that the three claimed disabilities were war-caused.

The Commission appealed to the Court on the ground that the AAT had erred in law by accepting Mr Richardson's hypothesis when there was no evidence to support his assertion that he witnessed dead and injured civilians.

The Court rejected that argument on the basis that the kernel of the hypothesis was not that the bodies or injured people Mr Richardson saw were civilians, but that he felt responsible for harm done to some people.

The Court held that it was open to the AAT to make the decision it did.

Formal decision

The Court dismissed the appeal and awarded costs to Mr Richardson.

AV *Clive Steel* (source: http://www.navsource.org/archives/10/14547.htm)

Statements of Principles issued by the Repatriation Medical Authority

April – June 2006

Number of Instrument	Description of Instrument
13 of 2006	Revocation of Statement of Principles (Instrument No 23 of 2001) and determination of Statement of Principles concerning **soft tissue sarcoma** and death from soft tissue sarcoma.
14 of 2006	Revocation of Statement of Principles (Instrument No 24 of 2001) and determination of Statement of Principles concerning **soft tissue sarcoma** and death from soft tissue sarcoma.
15 of 2006	Revocation of Statement of Principles (Instrument No 48 of 2004) and determination of Statement of Principles concerning **non melanotic malignant neoplasm of the skin** and death from non melanotic malignant neoplasm of the skin.
16 of 2006	Revocation of Statement of Principles (Instrument No 49 of 2004) and determination of Statement of Principles concerning **non melanotic malignant neoplasm of the skin** and death from non melanotic malignant neoplasm of the skin.
17 of 2006	Revocation of Statement of Principles (Instrument No 35 of 2001) and determination of Statement of Principles concerning **malignant neoplasm of the lung** and death from malignant neoplasm of the lung.
18 of 2006	Revocation of Statement of Principles (Instrument No 36 of 2001) and determination of Statement of Principles concerning **malignant neoplasm of the lung** and death from malignant neoplasm of the lung.
19 of 2006	Revocation of Statement of Principles (Instrument No 15 of 1996) and determination of Statement of Principles concerning **Paget's disease of the bone** and death from Paget's disease of the bone.
20 of 2006	Revocation of Statement of Principles (Instrument No 16 of 1996) and determination of Statement of Principles concerning **Paget's disease of the bone** and death from Paget's disease of the bone.
21 of 2006	Determination of Statement of Principles concerning **vascular dementia** and death from vascular dementia.
22 of 2006	Determination of Statement of Principles concerning **vascular dementia** and death from vascular dementia.
23 of 2006	Amendment of Statement of Principles (Instrument No 69 of 2001) concerning **open angle glaucoma** and death from open angle glaucoma.
24 of 2006	Amendment of Statement of Principles (Instrument No 70 of 2001) concerning **open angle glaucoma** and death from open angle glaucoma.

25 of 2006	Amendment of Statement of Principles (Instrument No 15 of 1999) concerning **angle-closure glaucoma** and death from angle-closure glaucoma.
26 of 2006	Amendment of Statement of Principles (Instrument No 16 of 1999) concerning **angle-closure glaucoma** and death from angle-closure glaucoma.
27 of 2006	Revocation of Statement of Principles (Instrument No 53 of 1997) and determination of Statement of Principles concerning **malignant neoplasm of the breast** and death from malignant neoplasm of the breast.
28 of 2006	Revocation of Statement of Principles (Instrument No 54 of 1997) and determination of Statement of Principles concerning **malignant neoplasm of the breast** and death from malignant neoplasm of the breast.
29 of 2006	Revocation of Statement of Principles (Instrument No 67 of 2002) and determination of Statement of Principles concerning **osteoporosis** and death from osteoporosis.
30 of 2006	Revocation of Statement of Principles (Instrument No 68 of 2002) and determination of Statement of Principles concerning **osteoporosis** and death from osteoporosis.
31 of 2006	Determination of Statement of Principles concerning **seborrhoeic keratosis** and death from seborrhoeic keratosis.
32 of 2006	Determination of Statement of Principles concerning **seborrhoeic keratosis** and death from seborrhoeic keratosis.
33 of 2006	Determination of Statement of Principles concerning **retinal vascular occlusive disease** and death from retinal vascular occlusive disease.
34 of 2006	Determination of Statement of Principles concerning **retinal vascular occlusive disease** and death from retinal vascular occlusive disease.

Copies of these instruments can be obtained from Repatriation Medical Authority, GPO Box 1014, Brisbane Qld 4001 or at *http://www.rma.gov.au/*

Conditions under Investigation by the Repatriation Medical Authority

as at 30 June 2006

Description of disease or injury	*SoPs under consideration*	Gazetted
Achilles tendonitis or bursitis	*Instrument Nos. 53/96 & 54/96*	19-11-03
Acute myeloid leukaemia	*Instrument Nos 169/96 & 170/96*	16-07-03
Acute sprains and acute strains	*Instrument Nos. 50/94 & 51/94*	19-11-03
Albinism	*Instrument Nos. 49/95 & 50/95*	15-06-05
Alkaptonuria	*Instrument Nos. 13/95 & 14/95 as amended by 188/95 & 189/95*	15-06-05
Alpha-1 antitrypsin deficiency	*Instrument Nos. 19/95 and 20/95*	15-06-05
Analgesic nephropathy	*Instrument Nos. 56/94 & 57/94 as amended by 277/95 & 278/95*	28-06-06
Anxiety disorder	*Instrument Nos. 1/00 & 2/00*	1-09-04
Benign prostatic hypertrophy	*Instrument Nos. 133/95 & 134/95*	28-06-06

Description of disease or injury	*SoPs under consideration*	Gazetted
Benign neoplasm of the eye	*Instrument Nos. 1825/95 & 183/95*	28-06-06
Binge eating disorder	—	15-06-05
Bipolar disorder	*Instrument Nos 128/96 & 129/96*	24-03-04
Caisson disease	*Instrument Nos 147/95 & 148/95*	31-03-04
Cardiac myxoma	*Instrument Nos. 13/98 & 14/98*	28-06-06
Cardiomyopathy	*Instrument Nos 19/98 & 20/98 as amended by 22/02 & 23/02*	2-03-05
Cataract, acquired	*Instrument Nos. 37 & 38 of 2001 as amended by 32/02 & 33/02*	1-03-06
Cataract, congenital	*Instrument Nos 237/95 & 238/95 as amended by 12/03 & 13/03*	15-06-05
Cerebrovascular accident	*Instrument Nos 30/02 & 31/02 as amended by 57/03 & 58/03*	15-06-05
Charcot-Marie-Tooth disease	*Instrument Nos 51/95 & 52/95*	15-06-05
Chicken pox	*Instrument Nos 58/94 and 59/94, as amended by 186/95 and 187/95*	15-06-05
Cholelithiasis	*Instrument Nos 33/94 & 34/94 as amended by 223/95 & 224/95 and 9/02 & 10/02*	28-06-06
Cirrhosis of the liver	*Instrument Nos 35/98 and 36/98*	02-11-05
Clonorchiasis	*Instrument Nos. 7/95 & 8/95*	28-06-06
Cuts, stabs, abrasions and lacerations	*Instrument Nos. 54/94 & 55/94*	28-06-06
Dental caries	*Instrument Nos. 366/95 & 367/95*	1-09-04
Depressive disorder	*Instrument Nos. 58/98 & 59/98*	1-09-04
Diverticular disease of the colon	*Instrument Nos. 67/94 & 68/94 as amended by 87/97 & 281/95*	28-06-06
Dyspepsia	—	7-09-05
External bruises and contusions	*Instrument Nos 43/94 & 44/94*	28-06-06
External burns	*Instrument Nos 37/94 & 38/94 as amended by 195/95 & 196/95*	25-02-04
Fibromuscular dysplasia	*Instrument Nos. 51/97 & 52/97*	28-06-06
Fracture	*Instrument Nos. 11/94 & 12/94 as amended by Nos. 219/95 & 220/95*	19-11-03
Gaucher's disease	*Instrument Nos. 21/95 & 22/95*	15-06-05
Haemophilia	*Instrument Nos. 53/95 & 54/95 as amended by 215/95 & 216/95*	15-06-05
Hallux valgus, acquired	*Instrument Nos. 47/98 & 48/98*	15-06-05
Hallux valgus, congenital	*Instrument Nos. 300/95 & 301/95*	15-06-05
Hepatitis A	*Instrument Nos 41/94 & 42/94*	15-06-05
Hepatitis E	*Instrument Nos 46/94 & 47/94*	15-06-05
Hereditary spherocytosis	*Instrument Nos 57/95 & 58/95*	15-06-05
Herpes zoster	*Instrument Nos 60/94 & 61/94*	15-06-05
Horseshoe kidney	*Instrument Nos 17/95 & 18/95*	15-06-05
Huntington's chorea	*Instrument Nos 107/95 & 108/95*	15-06-05
Idiopathic fibrosing alveolitis	*Instrument Nos 15/98 & 16/98*	15-06-05
Idiopathic thrombocytopaenic purpura	*Instrument Nos. 19/97 & 20/97*	28-06-06
Ingrown toenail	*Instrument Nos 13/94 & 14/94 as amended by 221/95 & 222/95*	28-06-06
Intervertebral disc prolapse	*Instrument Nos 130/96 & 131/96 as amended by 92/97 & 93/97*	23-06-04
Ischaemic heart disease	*Instrument Nos 53/03 & 54/03 as amended by 9/04 & 10/04*	15-06-05
Lipoma	*Instrument Nos. 69/95 & 70/95 as amended by 191/95 & 192/95*	28-06-06
Loss of teeth	*Instrument Nos 5/03 & 6/03*	2-03-05
Macular degeneration	*Instrument Nos. 25 and 26 of 2003*	1-03-06
Malignant melanoma of the skin	*Instrument Nos. 39 and 40 of 2001*	1-03-06

Description of disease or injury	*SoPs under consideration*	Gazetted
Malignant neoplasm of the bile duct	*Instrument Nos 17/00 & 18/00*	22-12-04
Malignant neoplasm of the bladder	*Instrument Nos 23/00 & 24/00*	28-12-05
Malignant neoplasm of the endometrium	*Instrument Nos 129/95 & 130/95 as amended by 183/96 & 184/96 and 45/03 & 46/03*	02-11-05
Malignant neoplasm of the lip epithelium	*Instrument Nos. 41/01 & 42/01 as amended by 49/01 & 50/01*	1-03-06
Malignant neoplasm of the oesophagus	*Instrument Nos. 115/96 & 116/96 as amended by 11/98 & 12/98*	1-09-04
Malignant neoplasm of the urethra	*Instrument Nos. 233/95 & 234/95*	28-06-06
Marfan syndrome	*Instrument Nos 9/95 & 10/95*	15-06-05
Meniere's disease	*Instrument Nos 77/01 & 78/01*	5-05-04
Mesothelioma	*Instrument Nos 52/94 & 53/94 as amended by 199/95 & 200/95*	28-06-06
Multiple osteochondromatosis	*Instrument Nos 1/99 & 2/99*	15-06-05
Myasthenia gravis	*Instrument Nos 263/95 & 264/95*	15-06-05
Myelodysplastic disorder	*Instrument Nos 15/00 & 16/00*	20-08-03
Myopia, hypermetropia and astigmatism	*Instrument Nos 23/99 & 24/99*	15-06-05
Non-melanotic malignant neoplasm of the skin	*Instrument Nos 15/06 & 16/06*	28-06-06
Opisthorchiasis	*Instrument Nos. 5/95 & 6/95 as amended by 125/95*	28-06-06
Osteogenesis imperfecta	*Instrument Nos. 11/95 & 12/95*	15-06-05
Otosclerosis	*Instrument Nos. 13/96 & 14/96*	28-06-06
Parkinson's disease	*Instrument Nos. 36/02 & 37/02*	2-03-05
Peptic ulcer disease	*Instrument Nos 21/99 & 22/99*	23-06-04
Peritoneal adhesions	—	1-03-06
Pinguecula	*Instrument Nos. 251/95 & 252/95*	28-06-06
Plantar fasciitis	*Instrument Nos.3/00 & 4/00 as amended by.47/03& 48/03*	19-11-03
Polycystic kidney disease	*Instrument Nos. 3/99 & 4/99 as amended by 54/99 & 55/99*	1-09-04
Polymyalgia rheumatica	*Instrument Nos. 89/96 & 90/96*	28-06-06
Post traumatic stress disorder	*Instrument Nos. 3/99 & 4/99 as amended by 54/99 & 55/99*	1-09-04
Presbyopia	*Instrument Nos. 314/95 & 315/95*	28-06-06
Pterygium	*Instrument Nos. 45 & 46 of 2001 as amended by Nos. 53 & 54 of 2001*	1-03-06
Pulmonary barotrauma	—	24-03-04
Rotator cuff syndrome	*Instrument Nos. 83/97 & 84/97*	19-11-03
Sarcoidosis	*Instrument Nos. 288/95 & 289/95*	28-06-06
Secondary parkinsonism	*Instrument Nos 38/02 & 39/02*	2-03-05
Shin splints	—	28-06-06
Sickle-cell disease	*Instrument Nos. 109/95 & 110/95 as amended by 193/95 & 194/95*	28-06-06
Spasmodic torticollis	*Instrument Nos. 33/97 & 34/97*	28-06-06
Spina bifida	*Instrument Nos 59/95 & 60/95*	15-06-05
Systemic lupus erythematosus	—	28-09-05
Trigeminal neuralgia	*Instrument Nos. 23/95 & 24/95*	28-06-06
Tuberculosis	*Instrument Nos. 81/97 & 82/97*	1-09-04
Von Willebrand's disease	*Instrument Nos. 61/95 & 62/95*	15-06-05
Wilson's disease	*Instrument Nos. 15/95 & 16/95*	15-06-05

AAT and Court decisions – April to June 2006

AATA = Administrative Appeals Tribunal
HCA = High Court of Australia
FCA = Federal Court
FCAFC = Full Court of the Federal Court
FMCA = Federal Magistrates Court
SRCA = *Safety, Rehabilitation and Compensation Act 1988*
Seafarers RCA = *Seafarers Rehabilitation and Compensation Act 1992*

Allowances and benefits

Repatriation pharmaceutical benefits card (Orange Card)
- whether rendered qualifying service
  Tomlin, M (Navy)
  [2006] AATA 551 23 Jun 2006

war grave commemoration
- claim not made by authorised person
  Mitchell, R
  [2006] AATA 361 7 Apr 2006

Carcinoma

colorectum
- alcohol
  Whelan, R L (RAAF)
  [2006] AATA 558 28 Jun 2006

larynx
- diagnosis
  Green, M (Army)
  [2006] AATA 397 8 May 2006
- smoking
  Green, M (Army)
  [2006] AATA 397 8 May 2006

Circulatory disorder

cerebral ischaemia
- acute hypotensive episode
  Jeffrey, A T (Army)
  [2006] AATA 565 27 Jun 2006
- dehydration
  Jeffrey, A T (Army)
  [2006] AATA 565 27 Jun 2006

cerebrovascular accident
- panic disorder
  McKay, M C (Army)
  [2006] AATA 190 (death) 2 Mar 2006

deep vein thrombosis
- ankle injury
  Blair, G M (Army)
  [2006] AATA 579 30 June 2006

hypertension
- alcohol abuse or dependence
  Gutteridge, G (Navy)
  [2006] AATA 324 6 Apr 2006
  Campbell, E R (Army)
  [2006] AATA 455 (death) 25 May 2006
- clinical onset
  Campbell, E R (Army)
  [2006] AATA 455 (death) 25 May 2006

ischaemic heart disease
- hypertension
  Campbell, E R (Army)
  [2006] AATA 455 (death) 25 May 2006
- obesity
  Lemay, A (RAAF)
  [2006] AATA 380 1 May 2006
- psychiatric disorder
  - depressive disorder
  Harris, P M (Army)
  [2006] AATA 357 (death) 18 Apr 2006
- smoking
  Lemay, A (RAAF)
  [2006] AATA 380 1 May 2006
  Holme, L (Navy)
  [2006] AATA 552 26 Jun 2006
  Oldham, J E (RAAF)
  [2006] AATA 568 29 Jun 2006

Claims

invalid claim
- claim not made by authorised person
  Mitchell, R
  [2006] AATA 361 7 Apr 2006

scope of a claim
- particularisation of injury or disease
  - whether claim for PTSD included claim for depression
  Philip, R
  [2006] AATA 427 17 May 2006

Date of effect

war widow's pension
- claim for war grave commemoration not relevant for date of effect
  Mitchell, R
  [2006] AATA 361 7 Apr 2006

Death

accidental death
- drowning
  - ischaemic heart disease
    Byrne, M (Army)
    [2006] AATA 416 12 May 2006
- motor vehicle accident
  - headaches and dizziness
    Streatfield, B (Army)
    [2006] AATA 185 1 Mar 2006

hastening of death
- fear of doctors
  Gittins, P A (Army)
  [2006] AATA 453 25 May 2006

kind of death
- correct diagnosis
  Streatfield, B (Army)
  [2006] AATA 185 1 Mar 2006
  Brown, E (Army)
  [2006] AATA 348 12 Apr 2006
  Harris, P M (Army)
  [2006] AATA 357 18 Apr 2006
- meaning
  Norris, S (Army)
  [2006] AATA 326 6 Apr 2006
- whether throat tumour was malignant
  Green, M (Army)
  [2006] AATA 397 8 May 2006

suicide
- alcohol
  Rhoades, H M (Navy)
  [2006] AATA 386 4 May 2006
- experiencing a severe psychosocial stressor
  - carcinoma of larynx
    Green, M (Army)
    [2006] AATA 397 8 May 2006
  - severe illness
    Green, M (Army)
    [2006] AATA 397 8 May 2006
- depression
  Rhoades, H M (Navy)
  [2006] AATA 386 4 May 2006
- post traumatic stress disorder
  Rhoades, H M (Navy)
  [2006] AATA 386 4 May 2006

terminal event
- haemorrhage
  Norris, S (Army)
  [2006] AATA 326 6 Apr 2006

Disability pension – assessment of incapacity

sequela
- whether included in assessment of original injury or disease
  Philip, R
  [2006] AATA 427 17 May 2006

Eligible service

qualifying service
- Butterworth, Malaysia
  - whether allotted for duty
    Kirk, R P (RAAF)
    [2006] AATA 469 30 May 2006
- whether eligible for campaign medal
  - 1939-45 Star
    Tomlin, M (Royal Navy)
    [2006] AATA 551 23 Jun 2006
- whether incurred danger from hostile forces of the enemy
  - trip from UK to Australia in 1945
    Tomlin, M (Royal Navy)
    [2006] AATA 551 23 Jun 2006

whether a veteran or member of the Forces
- discharged before rendering 3 years effective full-time service
  - behavioural problems
    Oxley, D (Army)
    [2006] AATA 350 12 Apr 2006
  - whether discharged for a medical reason
    Oxley, D (Army)
    [2006] AATA 350 12 Apr 2006
- whether rendered 3 years effective full-time service
  - period of absence without leave
    Robertson, J (Navy)
    [2006] AATA 366 26 Apr 2006

Endocrine and metabolic disorder

diabetes mellitus
- obesity
  - **Lemay, A** (RAAF)
    [2006] AATA 380 1 May 2006
- smoking
  - **Lemay, A** (RAAF)
    [2006] AATA 380 1 May 2006

Entitlement and liability

material contribution
- application to a psychiatric disorder
  - **Randall, K**
    [2006] AATA 433 (SRCA) 1 May 2006
- meaning
  - **Kidd, T D**
    [2006] AATA 378 (SRCA) 1 May 2006
  - **Randall, K**
    [2006] AATA 433 (SRCA) 1 May 2006

serious default or wilful act
- meaning
  - **Hardman, F M** (Seafarers RCA)
    [2006] AATA 468 30 May 2006

Statement of Principles factor
- alcohol consumption factor
  - meaning of 'cannot be decreased …'
    - **Campbell, E R** (Army)
      [2006] AATA 455 (death) 25 May 2006
- nonsensical factor
  - meaning of 'cannot be decreased …'
    - **Campbell, E R** (Army)
      [2006] AATA 455 (death) 25 May 2006

unintended consequence of medical treatment
- blindness
  - **Parker, R**
    [2006] AATA 440 (SRCA) 23 May 2006
- meaning of 'likely'
  - **Parker, R**
    [2006] AATA 440 (SRCA) 23 May 2006

Evidence and proof

application of *Deledio* steps
- assessment of the material
  - **Richardson** (Jarrett FM)
    [2006] FMCA 478 6 Apr 2006
- fact finding
  - **Patterson** (Heerey J)
    [2006] FCA 538 12 May 2006
- lack of evidence pointing to essential elements of hypothesis
  - **Streatfield, B** (Army)
    [2006] AATA 185 (death) 1 Mar 2006
  - **Rhoades, H M** (Navy)
    [2006] AATA 386 (death) 4 May 2006
- rejection of evidence beyond reasonable doubt at step 4
  - **Richardson** (Jarrett FM)
    [2006] FMCA 478 6 Apr 2006
  - **Rhoades, H M** (Navy)
    [2006] AATA 386 (death) 4 May 2006

assumption of facts
- inference of drinking alcohol to alleviate stress
  - **Norris, S** (Army)
    [2006] AATA 326 (death) 6 Apr 2006
- inference of suffering stress
  - **Norris, S** (Army)
    [2006] AATA 326 (death) 6 Apr 2006

credibility
- influence of pensions officer on witnesses' evidence
  - **Davies, B A** (Army)
    [2006] AATA 305 3 Apr 2006

insufficient evidence
- lack of evidence pointing to essential elements of hypothesis
  - **Streatfield, B** (Army)
    [2006] AATA 185 (death) 1 Mar 2006

kind of injury, disease or death
- standard of proof
  - kind of injury or disease in sub-hypothesis
    - **McKay, M C** (Army)
      [2006] AATA 190 (death) 2 Mar 2006

proofing of witnesses
- influence of pensions officer on witnesses' evidence
  - **Davies, B A** (Army)
    [2006] AATA 305 3 Apr 2006

witness statement
- usefulness in presentation of evidence
  - **Williams, E A**
    [2006] AATA 389 4 May 2006

Gastrointestinal disorder

irritable bowel syndrome
- psychiatric disorder
  - post traumatic stress disorder
    - **Briggs, J J** (Army)
      [2006] AATA 347 11 Apr 2006

Hepatic disorder

cirrhosis of the liver
- alcohol
Davies, B A (Army)
[2006] AATA 305 (death) 3 Apr 2006
Norris, S (Army)
[2006] AATA 326 (death) 6 Apr 2006

Historical material

World War 2
- Thursday Island
- Japanese activity
Davies, B A (Army)
[2006] AATA 305 3 Apr 2006

Incapacity for service or work

able to earn in suitable work
- failure to seek suitable work
- undertaking study
Fraser, L M
[2006] AATA 384 (SRCA) 3 May 2006
normal earnings
- overtime
- whether required to undertake overtime on a regular basis
Peisley (Wilcox, Conti, Stone JJ) (SRCA)
[2006] FCAFC 79 9 Jun 2006
normal weekly hours
- overtime
- whether required to undertake overtime on a regular basis
Peisley (Wilcox, Conti, Stone JJ) (SRCA)
[2006] FCAFC 79 9 Jun 2006

Injury and disease

sequela
- whether included in assessment
Philip, R
[2006] AATA 427 17 May 2006

Jurisdiction and powers

Administrative Appeals Tribunal
- exempt lump sum for income test purposes
- exemption cannot be determined on review
Beer, EW & EE
[2006] AATA 395 8 May 2006
- scope of review
- cannot determined matters that delegate could not have determined
Beer, EW & EE
[2006] AATA 395 8 May 2006
- cannot reconsider entitlement matter when reviewing assessment decision
Wodianicky, A
[2006] AATA 495 29 May 2006

Osteoarthrosis

hand
- joint pains during service
McHenry, E E (Army)
[2006] AATA 532 20 Jun 2006
hip
- joint pains during service
McHenry, E E (Army)
[2006] AATA 532 20 Jun 2006
knee
- joint pains during service
McHenry, E E (Army)
[2006] AATA 532 20 Jun 2006
- trauma
- twisting injury
Madler-Edwards, M (RAAF)
[2006] AATA 462 26 May 2006

Permanent impairment

assessment
- natural progression would have resulted in the same impairment
- impairment assessed as nil
Parker, R
[2006] AATA 440 (SRCA) 23 May 2006

Practice and procedure

alternative dispute resolution
- recommended
Campbell, E R (Army)
[2006] AATA 455 (death) 25 May 2006
representatives and pensions officers
- role and responsibilities
- preparation of claim
Davies, B A (Army)
[2006] AATA 305 3 Apr 2006
- proofing of witnesses
Davies, B A (Army)
[2006] AATA 305 3 Apr 2006

- responsibility not to influence evidence of witness
Davies, B A (Army)
[2006] AATA 305 3 Apr 2006

Psychiatric disorder

alcohol abuse or dependence
- clinical onset
Walker, R W (Navy)
[2006] AATA 290 29 Mar 2006
Lloyd, C (Navy)
[2006] AATA 335 10 Apr 2006
- diagnosis
White, R (Navy)
[2006] AATA 293 29 Mar 2006
- experiencing a severe stressor
- action stations
Walker, R W (Navy)
[2006] AATA 290 29 Mar 2006
- aircraft crash
Mayfield, K (RAAF)
[2006] AATA 514 14 Jun 2006
- assaulted
Lloyd, C (Navy)
[2006] AATA 335 10 Apr 2006
- boiler room incident
White, R (Navy)
[2006] AATA 293 29 Mar 2006
Rhoades, H M (Navy)
[2006] AATA 386 (death) 4 May 2006
- death of colleague
White, R (Navy)
[2006] AATA 293 29 Mar 2006
- firing shells that might have injured civilians
Donnelly, J F (Navy)
[2006] AATA 534 21 Jun 2006
- fuel dump proximity
Mayfield, K (RAAF)
[2006] AATA 514 14 Jun 2006
- meaning
Constable (Spender, Weinberg, Edmonds JJ)
[2006] FCAFC 102 26 Jun 2006
- red alert at Ubon
Mayfield, K (RAAF)
[2006] AATA 514 14 Jun 2006
- scare charges
Walker, R W (Navy)
[2006] AATA 290 29 Mar 2006
White, R (Navy)
[2006] AATA 293 29 Mar 2006
- trapped in freezer
Lloyd, C (Navy)
[2006] AATA 335 10 Apr 2006
- witnessed battle activity
Walker, R W (Navy)
[2006] AATA 290 29 Mar 2006
- woken up while being evacuated from diesel fumes
Lloyd, C (Navy)
[2006] AATA 335 10 Apr 2006
- psychiatric disorder
- post traumatic stress disorder
Gutteridge, G (Navy)
[2006] AATA 324 6 Apr 2006
- service environment
Bassett, D (RAAF)
[2006] AATA 562 28 Jun 2006
anxiety disorder
- clinical onset
Lloyd, C (Navy)
[2006] AATA 335 10 Apr 2006
McNally, B (Navy)
[2006] AATA 393 8 May 2006
- not within 2 years of alleged stressor
Livings, B (RAAF)
[2006] AATA 574 30 Jun 2006
- diagnosis
Livings, B (RAAF)
[2006] AATA 574 30 Jun 2006
- experiencing a severe stressor
- assaulted
Lloyd, C (Navy)
[2006] AATA 335 10 Apr 2006
Livings, B (RAAF)
[2006] AATA 574 30 Jun 2006
- casualty clearance
Livings, B (RAAF)
[2006] AATA 574 30 Jun 2006
- confined conditions in ship
Robertson, J (Navy)
[2006] AATA 366 26 Apr 2006
- helicopter crash
Livings, B (RAAF)
[2006] AATA 574 30 Jun 2006
- Hell's Highway, Kuwait
McNally, B (Navy)
[2006] AATA 393 8 May 2006

- Operation Awkward
Robertson, J (Navy)
[2006] AATA 366 26 Apr 2006
- photographs of dead bodies
McNally, B (Navy)
[2006] AATA 393 8 May 2006
- rocket attack
Livings, B (RAAF)
[2006] AATA 574 30 Jun 2006
- shot at
Livings, B (RAAF)
[2006] AATA 574 30 Jun 2006
- trapped in freezer
Lloyd, C (Navy)
[2006] AATA 335 10 Apr 2006
- warning shots fired
McNally, B (Navy)
[2006] AATA 393 8 May 2006
- woken up while being evacuated from diesel fumes
Lloyd, C (Navy)
[2006] AATA 335 10 Apr 2006
- identifiable occurrence
- assessment of
McNally, B (Navy)
[2006] AATA 393 8 May 2006
- substantial distress
- meaning
McNally, B (Navy)
[2006] AATA 393 8 May 2006
depressive disorder
- experiencing a severe stressor
- boiler room incident
Rhoades, H M (Navy)
[2006] AATA 386 (death) 4 May 2006
panic disorder
- clinical onset
McKay, M C (Army)
[2006] AATA 190 (death) 2 Mar 2006
phobia
- fear of doctors
- diagnosis
Gittins, P A (Army)
[2006] AATA 453 (death) 25 May 2006
- situational
- diagnosis
Parkes, G (Navy)
[2006] AATA 405 10 May 2006
post traumatic stress disorder
- diagnosis
White, R (Navy)
[2006] AATA 293 29 Mar 2006
Rankin, B (RAAF)
[2006] AATA 341 10 Apr 2006
Livings, B (RAAF)
[2006] AATA 574 30 Jun 2006
- experiencing a severe stressor
- accidental weapon discharge
McVeigh, N W (Navy)
[2006] AATA 330 7 Apr 2006
- aircraft crash
Rankin, B (RAAF)
[2006] AATA 341 10 Apr 2006
- assault
Rankin, B (RAAF)
[2006] AATA 341 10 Apr 2006
- boiler room incident
White, R (Navy)
[2006] AATA 293 29 Mar 2006
Rhoades, H M (Navy)
[2006] AATA 386 (death) 4 May 2006
- death of colleague
White, R (Navy)
[2006] AATA 293 29 Mar 2006
- fear of mines
Binding, K D (Navy)
[2006] AATA 516 14 Jun 2006
- fear that shell might explode
Gutteridge, G (Navy)
[2006] AATA 324 6 Apr 2006
- fire in the ship
Brown, J F (Navy)
[2006] AATA 445 22 May 2006
- firing shells that might have injured civilians
Donnelly, J F (Navy)
[2006] AATA 534 21 Jun 2006
- foot trapped in hoist
Gutteridge, G (Navy)
[2006] AATA 324 6 Apr 2006
- scare charges
White, R (Navy)
[2006] AATA 293 29 Mar 2006
Binding, K D (Navy)
[2006] AATA 516 14 Jun 2006
- shooting of guard
Rankin, B (RAAF)
[2006] AATA 341 10 Apr 2006

- threatened with gun
Briggs, J J (Army)
[2006] AATA 347 11 Apr 2006
- witnessed shooting
Briggs, J J (Army)
[2006] AATA 347 11 Apr 2006

Rehabilitation and treatment

treatment
- meaning
Ragg, A
[2006] AATA 414 (SRCA) 12 May 2006
- whether treatment reasonable
- complementary medicines
Farrugia, N
[2006] AATA 438 (SRCA) 22 May 2006
- exercise bike
Ragg, A
[2006] AATA 414 (SRCA) 12 May 2006

Remunerative work & special rate of pension

capacity to undertake remunerative work
- capacity to work more than 8 but less than 20 hours a week
Harris, L J
[2006] AATA 567 29 Jun 2006
- not due to incapacity from accepted disabilities of itself alone
Young, R
[2006] AATA 448 24 May 2006
- whether temporarily incapacitated
Leigh (Dowsett J)
[2006] FCA 395 12 Apr 2006
ceased to engage in remunerative work
- reason for ceasing last job not the reason for ceasing work
Crabb, R
[2006] AATA 295 15 Mar 2006
Higgins, R
[2006] AATA 327 7 Apr 2006
- voluntary redundancy
Higgins, R
[2006] AATA 327 7 Apr 2006
kind of work the person was undertaking
- accounting / finance
- bank officer
Crabb, R
[2006] AATA 295 15 Mar 2006
- administrative
- clerical officer
Crabb, R
[2006] AATA 295 15 Mar 2006
Cole, G R
[2006] AATA 316 5 Apr 2006
Mayfield, K
[2006] AATA 514 14 Jun 2006
- defence
- diver
Godfrey, J
[2006] AATA 442 23 May 2006
- engineering
- civil / construction
- bricklayer
Williams, E A
[2006] AATA 389 4 May 2006
- builder
Williams, E A
[2006] AATA 389 4 May 2006
- manual labourer
Taylor, J
[2006] AATA 464 26 May 2006
- roof trusser
Williams, E A
[2006] AATA 389 4 May 2006
- marine
- marine engine maintenance
Godfrey, J
[2006] AATA 442 23 May 2006
- maintenance analyst
Walker, R W
[2006] AATA 290 29 Mar 2006
- legal
- process server
Mayfield, K
[2006] AATA 514 14 Jun 2006
- manufacturing
- plant operator
Harris, L J
[2006] AATA 567 29 Jun 2006
- mining
- labourer
Higgins, R
[2006] AATA 327 7 Apr 2006
Johnston, R
[2006] AATA 511 13 Jun 2006
- miner
Crabb, R
[2006] AATA 295 15 Mar 2006

- transport
  - driver
    Wodianicky, A
    [2006] AATA 495 29 May 2006
remunerative work
- meaning
  Butcher (Besanko J)
  [2006] FCA 811 30 Jun 2006
time at which criteria to be met
- during the assessment period
  Crabb, R
  [2006] AATA 295 15 Mar 2006
whether genuinely seeking to engage in remunerative work
- advice from Centrelink
  Harris, L J
  [2006] AATA 567 29 Jun 2006
- applied for bus driving licence
  Williams, E A
  [2006] AATA 389 4 May 2006
- checked newspaper advertisements
  Higgins, R
  [2006] AATA 327 7 Apr 2006
- Jobsearch program
  Higgins, R
  [2006] AATA 327 7 Apr 2006
- not seeking work within the assessment period
  Williams, E A
  [2006] AATA 389 4 May 2006
- paid newstart allowance
  Williams, E A
  [2006] AATA 389 4 May 2006
whether prevented by war-caused disabilities alone
- age
  Higgins, R
  [2006] AATA 327 7 Apr 2006
  Cole, G R
  [2006] AATA 316 5 Apr 2006
- effects of non-accepted disabilities
  Young, R
  [2006] AATA 448 24 May 2006
  Wodianicky, A
  [2006] AATA 495 29 May 2006
  Johnston, R
  [2006] AATA 511 13 Jun 2006
  Bassett, D
  [2006] AATA 562 28 Jun 2006
  - not significant
    Harris, L J
    [2006] AATA 567 29 Jun 2006
- service pension availability
  Taylor, J
  [2006] AATA 464 26 May 2006
- redundancy
  Harris, L J
  [2006] AATA 567 29 Jun 2006
- retirement plans
  Walker, R W
  [2006] AATA 290 29 Mar 2006
- time out of the workforce
  Cole, G R
  [2006] AATA 316 5 Apr 2006
- unhappy with workplace pay and conditions
  Walker, R W
  [2006] AATA 290 29 Mar 2006

Service pension

asset test
- principal home
  - value of land in excess of 2 hectares curtilage
    Highnam, D
    [2006] AATA 500 8 Jun 2006
    Hercules, R A
    [2006] AATA 583 23 Jun 2006
failure to comply with a section 54 notice
- income
  Westerman, AH & LD
  [2006] AATA 530 20 Jun 2006
income test
- exempt lump sum
  - exemption cannot be determined on review
    Beer, EW & EE
    [2006] AATA 395 8 May 2006
- proceeds of life insurance policy
  - profit or bonus component is 'income amount'
    Beer, EW & EE
    [2006] AATA 395 8 May 2006
  - valuation of profit component
    Beer, EW & EE
    [2006] AATA 395 8 May 2006
- salary sacrifice
  Westerman, AH & LD
  [2006] AATA 530 20 Jun 2006

raising of overpayment
- not reviewable
Holt, J W
[2006] AATA 537 22 Jun 2006
recovery of overpayment
- not reviewable
Westerman, AH & LD
[2006] AATA 530 20 Jun 2006
Holt, J W
[2006] AATA 537 22 Jun 2006

Skin disorder

dermatitis
- endogenous dermatitis
- aggravation
McNally, B (Navy)
[2006] AATA 393 8 May 2006
- environmental factors
McNally, B (Navy)
[2006] AATA 393 8 May 2006
- secondary contact dermatitis
- aggravation
McNally, B (Navy)
[2006] AATA 393 8 May 2006
- environmental factors
McNally, B (Navy)
[2006] AATA 393 8 May 2006

Spinal disorder

cervical spondylosis
- trauma
- head injury
Collins, H E R (Navy)
[2006] AATA 364 24 Apr 2006
intervertebral disc prolapse
- smoking
Willcoxson, M (Navy)
[2006] AATA 447 24 May 2006
lumbar spondylosis
- intervertebral disc prolapse
Willcoxson, M (Navy)
[2006] AATA 447 24 May 2006
- rowing
Poole, D (Army)
[2006] AATA 323 24 Mar 2006

Visual disorder

diplopia
- fumes from aviation fuel
Bassett, D (RAAF)
[2006] AATA 562 28 Jun 2006

Words and phrases

cannot be decreased
- alcohol consumption factor
- no meaning can be given to the phrase
Campbell, E R (Army)
[2006] AATA 455 (death) 25 May 2006
carrying
Poole, D (Army)
[2006] AATA 323 24 Mar 2006
experiencing a severe stressor
Constable (Spender, Weinberg, Edmonds JJ)
[2006] FCAFC 102 26 Jun 2006
inability to obtain appropriate clinical management
- injury or disease must have existed before or during eligible service
Gittins, P A (Army)
[2006] AATA 453 25 May 2006
intense fear, helplessness or horror
Constable (Spender, Weinberg, Edmonds JJ)
[2006] FCAFC 102 26 Jun 2006
lifting
Poole, D (Army)
[2006] AATA 323 24 Mar 2006
permanently incapacitated
Leigh (Dowsett J)
[2006] FCA 395 12 Apr 2006
residence
Baccon (Branson J)
[2006] FCA 773 (SSA) 21 Jun 2006
substantial distress
- meaning
McNally, B (Navy)
[2006] AATA 393 8 May 2006