VeRBosity

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Editor's notes

This edition of *VeRBosity* reports on the conclusion of the *Roncevich* case and subsequent appeals. The claim was rejected by the Commission and that decision was affirmed by the VRB, then the AAT. A single judge of the Federal Court upheld an appeal and remitted it to the AAT, which again affirmed the rejection of the claim. Again it was appealed to the Federal Court, which dismissed the appeal. An appeal to the Full Federal Court was also dismissed, by a 2-1 majority. Finally the High Court upheld an appeal and remitted it to be reheard by the AAT. In the end …, well perhaps I shouldn't spoil the ending (see the report of the AAT case at page 100). In the course of this long-running case we have been left with some useful insights into what is meant by 'rendering service' and the connections that might be made between injuries and events that happen when a person is not 'on duty'.

The first article in this edition relates to the exclusion provisions in the MRCA. To a large extent they mirror the exclusions in the VEA, but there are some significant differences that warrant close attention.

The second article answers some commonly asked questions concerning the special rate of pension. This remains a difficult subject and the question and answer format may assist practitioners in answering veterans' queries.

Trina McConnell
Editor

Exclusion provisions in the MRCA

Similar exclusions apply to the acceptance of injury, disease and death under the *Military Rehabilitation and Compensation Act 2004* (the MRCA) as apply under the VEA. Unlike under the VEA, if the injury or disease causes serious and permanent impairment or the exclusory circumstance causes the person's death, not all of the exclusions apply.

The exclusions that ***do not apply*** to **serious and permanent impairment** or **death** include:

- serious default;
- wilful act;
- serious breach of discipline;
- self-inflicted injury;
- taking alcohol or unauthorised drug.

The exclusions that ***do not apply*** to **death** but ***do apply*** to **serious and permanent impairment** include:

- resulted from reasonable counselling in connection with performance as a member;
- resulted from failure to obtain a promotion, transfer, or benefit.

The exclusions that ***do apply*** to injury and disease including those resulting in serious and permanent impairment, and to death include:

- wilful and false representation in connection with the person's defence service or proposed defence service that he or she did not suffer, or had previously not suffered, from the claimed injury or disease or that resulted in his or her death;
- in relation to journeys to or from undertaking duty:
  - substantial delay in commencing the journey;
  - indirect route;
  - substantial interruption to the journey,

  which substantially increased the risk of injury, disease or death;
- if the only service-related cause of injury, disease or death is the use of tobacco products.

Exclusions apply even if there are other causes

It might be that there are a number of contributing causes to an injury or disease or its aggravation. In *Trewin v Comcare*,[1] Heerey J said:

> … if there were four contributing and employment-related factors, of which three were exclusionary and one was not … the claim would succeed.

However, in *Hart v Comcare*,[2] the Full Federal Court disagreed with this view and held that liability was excluded even if other non-excluded causes could link the injury with employment.[3]

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[1] *Trewin v Comcare* (1998) 84 FCR 171.

[2] *Hart v Comcare* [2005] FCAFC 16.

[3] The High Court refused special leave to appeal in *Hart*. While *Hart* concerned different legislation, the same principles would apply to s 34 of the MRCA.

While these cases concerned the *Safety, Rehabilitation and Compensation Act 1988* (the SRCA), the same reasoning in *Hart v Comcare* would probably apply under the MRCA. An exception to this is the exclusion in s 36 of the MRCA concerning tobacco use (see below).

Serious default or wilful act — s 32

Like the VEA, the MRCA excludes liability if the injury or disease resulted from the member's serious default or wilful act.[4]

Serious default

Generally a 'default' is thought of as an omission or a failure to do something. In the context of the VEA and MRCA, the default in question must be 'serious'. Seriousness may be assessed by the nature of the default itself or its consequences.

In *Bagot v Commissioner for Railways*,[5] Jordan CJ said:

> Default means failure by the worker to comply with a legal duty to be careful, the failure being of a kind inherently likely to cause disabling physical injury to himself, and in fact causing or contributing to the injury in question

In *Girlock* (*Sales*) *Pty Ltd v Hurrell*,[6] Mason J referred to this statement and said that an involuntary act cannot constitute a default. Mason J held that a person may get so drunk as to not act voluntarily and, in that state, could not be in default because default requires voluntariness. In a military context 'drunkenness' may be a serious default.

Wilful act

A 'wilful act' indicates conduct that is blameworthy and deserving of serious censure.[7] To qualify as 'wilful' an act must be voluntary and intentional. In *R v Senior*,[8] Lord Russell of Killowen said:

> Wilfully means that the act is done deliberately and intentionally, not by accident or inadvertence, but so that the mind of the person goes with it.

In criminal law, a person may be so drunk as to be incapable of forming the requisite intention at the time of an act to be guilty of the offence. When a person is in such a state it is not permissible to substitute the general intention to become drunk for the specific intention to do the act in question.[9] However if a person is affected by alcohol only to the extent that he or she is more ready than usual to commit a crime then that condition will afford the person no defence. Similar considerations would apply to the 'wilful act' exclusion in the VEA and MRCA.[10]

Compare s 34 to s 36, in which the exclusion applies only if no other connection with service applies.

[4] Section 32, MRCA.

[5] *Bagot v Commissioner for Railways* (1943) 44 SR (NSW) 173 at 175.

[6] *Girlock* (*Sales*) *Pty Ltd v Hurrell* (1982) 40 ALR 45.

[7] *Ferriday v Repatriation Commission* (1996) 69 FCR 521.

[8] *R v Senior* [1899] 1 QB 283 at 291.

[9] *R v O'Connor* (1980) 54 ALJR 349.

[10] In *Re McGrath and Repatriation Commission* (unreported, 13 November 1989) at paragraph [28] the AAT considered that criminal law defences were appropriate analogies that could be applied in the context of the exclusions in the VEA.

In *McPherson's* case,[11] the Court said:

> … 'wilful act' connotes conduct which is blameworthy and deserving of serious censure. The effect of depriving a veteran of a pension to which he is otherwise entitled is to penalise him severely. The legislature cannot have intended that such a severe penalty should be visited upon a veteran in the absence of conduct warranting severe condemnation.

Exclusion does not apply to death or serious impairment

The serious default or wilful act exclusion does not apply to the death of a member, or if the injury or disease results in 'serious and permanent impairment'.

Whether an injury or disease has resulted in serious and permanent impairment is a determined on the basis of expert medical opinion. The issue of permanence might take a long time to resolve. That is, it might be necessary to wait until after treatment and healing have run their course before it can be said that the serious impairment from an injury or disease is permanent.

Applies only to acts while a member

Unlike the VEA, the MRCA does not extend this exclusion to serious defaults or wilful acts committed after the person ceased to be a serving member of the ADF. The MRCA limits exclusion of liability from such acts to those committed 'while a member'.[12]

Extended application of exclusions

The MRCA adds to the serious default or wilful act exclusions. The Act deems the consumption of alcohol or an unauthorised drug to be a 'serious default or wilful act' if the injury or disease 'resulted from being under the influence' of the alcohol or drug. This exclusion is discussed below under 'alcohol or unauthorised drugs' at p 92.

Serious breach of discipline — s 32

Like the VEA, liability is excluded under the MRCA if the injury or disease '***arose from*** a serious breach of discipline committed by the veteran', or '***arose from*** an occurrence that occurred while the veteran was committing a serious breach of discipline'.

The serious breach of discipline exclusion does not apply to the death of a member, or if the injury or disease results in 'serious and permanent impairment'.

A breach of discipline obviously occurs if a veteran or member has contravened the rules or orders applying at the time of their conduct. It may be harder to establish if that breach was 'serious'.

In *Re Nelson,*[13] the veteran had been court-martialled for desertion and while in prison developed an anxiety state. The Tribunal's view was that while it was difficult to determine, any breach that results in imprisonment should be regarded as 'serious'. The AAT considered that even if it were established that there was something

[11] *McPherson v Repatriation Commission* (1989) 8 AAR 229

[12] Paragraph 32(1)(a), MRCA. Compare this with s 8(3), 9(4) and 70(10), VEA.

[13] *Re Nelson and Repatriation Commission* (1988) 15 ALD 49

unusual about the gaol conditions under which the applicant laboured, his anxiety state must nevertheless be regarded as the result of the serious default which led him to prison in the first place.

In *Levi's* case,[14] the veteran became a heroin addict while in Vietnam. The Federal Court took the view that this was not a serious breach because:

> [the concession by the Commission] that the addiction was war-caused either excludes a finding that it was self-caused, or so affects the situation that it should not be accepted as a statutory disentitlement to a pension …
>
> There was no evidence that any other person taking or becoming addicted to a drug has ever been so considered, especially where the addiction has been found, as is here conceded, to be a consequence of war service. [A document listing penalties for marijuana offences indicated that many offences were dealt with as quite minor and there was no evidence to suggest that taking heroin would attract more serious penalties.]
>
> … this document thus represented what amounted to an admission by the Army that heroin use or dependence did not inevitably constitute a serious breach of discipline. The same may be said for the criteria of section 9(3)(a) both limbs of which are in any event inconsistent with an unwitting addiction. As it may also be assumed that there were a number of drug takers or dealers who were not detected at all, it cannot be the position that the ultimate entitlement to a veteran's pension turns in principle upon such circumstantial treatment of the very same acts.

Mr Measures claimed PTSD on the basis a motor vehicle accident in Vietnam in which a child was killed.

As a result of the accident he was charged with causing death by dangerous driving and conduct to the prejudice of good order and military discipline.

A General Court Martial found him guilty and sentenced him to a period of detention of one year, which was subsequently mitigated to 9 months. He was released early due to his good behaviour in gaol.

The AAT found that this constituted a serious breach of discipline to preclude acceptance of his claim.

Re Measures [2003] AATA 909.

Therefore each case must be taken on its merits and considered carefully with regard to what results could have occurred from the breach of discipline, including the nature of the penalty involved. This does not mean that breaches attracting a lesser penalty are not 'serious'.

Since at least October 1980 the ADF has had a policy of zero tolerance to prohibited substance use. Use of a prohibited substance during service on or after 24 October 1980 may therefore be regarded as a serious breach of discipline and liability for any claim involving that substance use during service may be excluded under sections 8(2), 9(3) or 70(9) of the VEA.

Although the ADF does not have a zero tolerance policy in relation to alcohol, there may be some cases where alcohol consumption may give rise to the application of sections 8(2), 9(3) or 70(9) of the VEA.

[14] *Repatriation Commission v Levi* (1994) 33 ALD 79

The Chief of the ADF has determined that a 'narcotic substance as defined in the *Customs Act 1901*, or any other substance determined to be a prohibited substance by the Chief of the Defence Force' is a prohibited substance for members of the ADF.

Simple cases of being absent without leave for short periods or other infringements of discipline that do not result in significant penalties such as imprisonment or discharge would probably not meet the criteria of 'serious'. However, if the person is absent without leave the person is unlikely to be taken to be 'rendering service', and so would not come within the liability provisions in the first place (except perhaps if the person were taken to be rendering operational service in an operational area).

Skylarking that results in injury might be considered to be a 'wilful act' but again, this would depend on the circumstances of the case. If such skylarking has taken place previously and the military authorities have made no attempt to end the practice, the fact that injury results on a specific occasion would not be enough to turn it into a 'wilful act'. The test would therefore be its relationship to the person's duties. Actions resulting in civil charges would likely be classed as 'serious'.

Tobacco use — s 36

The MRCA excludes liability for injury, disease or death if the only connection with service is by means of the use of tobacco products. If use of tobacco were merely one of the causes, entitlement is not precluded.[15]

Self-inflicted injury — s 32

Unlike the VEA, the MRCA expressly mentions 'self-inflicted injury' as an exclusion of liability.[16] This is one of the exclusions of liability in the SRCA.[17]

Exclusion does not apply to death claims

The serious default or wilful act exclusion does not apply to the death of a member, or if the injury or disease results in 'serious and permanent impairment'. This means that the exclusion cannot be applied to deny liability for a person's suicide.

Alcohol or unauthorised drugs — s 32

The consumption of alcohol or a drug is taken to be a 'serious default or wilful act' if the injury or disease 'resulted from being under the influence' of the alcohol or drug.

Drug use will not exclude liability if:

- it was administered by a person legally authorised to administer the drug; or
- it was legally obtained and taken in accordance with the directions provided with the drug.

An important part of the exclusion is that the injury or disease resulted from being 'under the influence' of alcohol or the relevant drug. While the phrase is not defined, it would likely require evidence

[15] Section 36, MRCA.

[16] Paragraph 32(1)(c), s 32(3)(b)(iv), s 32(4)(b)(iv), MRCA.

[17] Subsection 14(2), SRCA.

that the person's actions or faculties were affected by alcohol or the particular drug. In *GIO NSW v Nowalinski*,[18] Grove J said:

> There must be some limit of relevance circumscribing the words, 'under the influence of intoxicating liquor' as used in the policy. In the broadest sense all ingested matter contributes to the function or malfunction of the human body and thereby is an influence upon it. The scope of the exclusion is obviously not wide enough to include influencing in that extreme sense. The test adopted of disturbance to mind or faculty was in my opinion appropriate and applicable.

For liability to be excluded, the cause of the injury or disease must have been directly related to the effect the alcohol or drug had on the person's actions.

Exclusion does not apply to death claims

The serious default or wilful act exclusion does not apply to the death of a member, or if the injury or disease results in 'serious and permanent impairment'.

Reasonable counselling in connection with performance as a member—s 33

Liability cannot be accepted if the injury or disease resulted from reasonable counselling in relation to the member's performance as a member.[19]

This exclusion is similar to, but potentially broader[20] in effect than an exclusion in the SRCA concerning injury caused by 'reasonable disciplinary action'.[21] Under the SRCA, reasonable disciplinary action had to be taken *against* the person. Under the MRCA, 'reasonable counselling' is not necessarily an action taken against the member. It may be conducted for the member's benefit. If such counselling was reasonable yet caused an injury or disease, or aggravated an injury or disease (or sign or symptom), liability could not be accepted for that injury or disease.

In *Re Tan and Comcare*,[22] the AAT said:

> [35] … We have had regard to the definition of the verb 'counsel' in Volume 1 of the *Shorter Oxford Dictionary*. Having done so, we rule that 'counselling' is constituted by 'advice, direction, as the result of deliberation' – in other words, counselling is constituted by steps taken in the way of advice offered or instructions given to the worker by the superior as the result of deliberation by the superior upon what is revealed by inquiry or investigation. If the inquiry or investigation reveals the need for advice or instruction to the employee, it is the giving of the advice or of the instruction which constitutes 'counselling'.

The reasonableness of counselling depends on the manner in which it was conducted. In certain situations a member would need to be given notice of the counselling before it was conducted, and the counselling would probably need to conform with the appropriate standard

[18] *GIO NSW v Nowalinski* (1985) 2 MVR 142.

[19] Paragraph 33(1)(a), s 33(2)(b)(i), s 33(3)(b)(i), MRCA.

[20] Counselling was not held to be part of disciplinary action in *Re Tan and Comcare* (unreported, 15 September 1997).

[21] Definition of 'injury' n s 4(1), SRCA.

[22] *Re Tan and Comcare* (unreported, 15 September 1997)

for counselling operating in the arm of the ADF in which the member served.

Exclusion does not apply to death claims

This exclusion does not apply to claims relating to a member's death.

Failure to obtain a promotion, transfer, or benefit—s 33

Liability cannot be accepted if the injury or disease resulted from a failure to obtain a promotion, transfer or benefit in relation to the person's service as a member. [23]

A downgrading or demotion is not a failure to obtain a promotion, transfer, or benefit.[24] A failure to *retain* a benefit is not the same as a failure to *obtain* a benefit. [25] However, a failure to obtain a position at the same level has been held to be a failure to obtain a benefit.[26] It would also fall within the 'transfer' exclusion.[27]

In *Golds v Comcare*,[28] Cooper J said:

> [42] … The phrase 'failure ... to obtain a promotion, transfer or benefit in connection with ... employment' must be read in the context of Commonwealth employment, which involves the creation of positions within a classified hierarchy. A promotion in this context means no more than to advance to a higher position in the bureaucratic structure. It is not necessary that the phrase be limited to a failure to be promoted to a specific position for which the person was an applicant. The legislative intention … both permits and requires that disappointed hopes of advancement by promotion within the system which cause or contribute to a disease or illness be excluded as circumstances giving rise to compensable injury.

This provision excludes liability only if the 'failure to obtain' actually had the effect of causing, aggravating or materially contributing to the injury or disease (or symptom of the injury or disease [29]).

Exclusion does not apply to death claims

This exclusion applies only to claims for liability for injury or disease, it does not apply to claims relating to a member's death.

Wilful and false representation — s 34

Liability cannot be accepted if the injury or disease if the member made a wilful and false representation, in connection with his or her defence service, that he or she did not suffer or had not previously suffered, from that injury or disease.

Exclusion applies to death claims

Unlike most of the other exclusions in the MRCA, this exclusion also applies to claims relating to a member's death.

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[23] Paragraph 33(1)(b), s 33(2)(b)(ii), s 33(3)(b)(ii), MRCA.

[24] *Re Davill and Australian Postal Corporation* (unreported, 22 December 1995).

[25] *Comcare v Ross* (unreported, 2 August 1996).

[26] *Re Patrick and Comcare* (unreported, 12 February 1997).

[27] *Re MacFarlane and Comcare* (1998) 58 ALD 304.

[28] *Golds v Comcare* [1999] FCA 1481.

[29] Subparagraph 33(3)(b)(ii), MRCA.

Substantially increased risk of injury in journeys — s 35

The same travel exclusions that apply under the VEA, apply under the MRCA.[30] An injury or disease cannot be accepted as war-caused or defence-caused if the person's risk of injury was substantially increased because:

- the journey was delayed;[31]
- the route was not reasonably direct;[32] or
- there was a substantial interruption in the journey.[33]

Extended application of the journey exclusions

Under the MRCA, the exclusions relating to travel apply not only to the specific travelling provisions in s 27(e) and s 28(1)(f), which concern travelling to or from a place for the purpose of undertaking duty, but also to ***any other*** provision in sections 27, 28, or 30 that, in a particular case, raises a connection between a ***peacetime*** service-related journey and injury, disease or death. The Note to s 35(1)) says:

> This section applies if the injury, disease or death is a service injury, disease or death because of the application of any of sections 27, 28, and 30 (not only paragraphs 27(e) and 28(1)(f)).

Journey exclusions apply only to peacetime service

Neither the journey provisions nor the specific journey-related exclusions apply to warlike or non-warlike service under the MRCA.

Mr Alcock ceased duty at 3.15pm on Friday. He planned to drive to his parent's home (about 2 hours drive by direct route) . He left his barracks at 10am on Saturday morning and then detoured by a route that added 3 hours to the journey. He stopped for lunch and resumed the journey in the late afternoon. At 6pm he was involved in an accident. It was dark at the time.

The AAT held that the substantial delay and the particular route chosen did not substantially alter the risk.

However, the AAT held that the fact that the journey during which the accident occurred took place in darkness did substantially increase the risk of injury, and so the claim was refused.

Re Alcock (1992) 28 ALD 73.

[30] Section 35, MRCA.

[31] Subsection 35(3), MRCA.

[32] Subsection 35(4), MRCA.

[33] Subsection 35(5), MRCA.

Frequently asked questions about the special rate of pension

Is it reasonable to expect a person who has had extensive professional experience, but who is now incapable of that kind of work, to be undertaking unskilled work?

The question is not whether it would be reasonable for the *applicant* to do such work, but whether a *hypothetical fit person* who has the same skills, qualifications and experience as the applicant might reasonably undertake such work (**s 28(b)**).[34] This means that the applicant's attitude to such work is not particularly relevant. It is for the decision-maker to decide whether 'a person' with the applicant's background skills, qualifications and experience might reasonably undertake the work. In answering this question it may be relevant that the person's work experience includes the fact that he was a high level executive or distinguished member of his or her profession.

> Mr Tinkler had a distinguished military career and had worked in a senior position in a university. He said that he could not come down to the level of working as a book keeper in a small business and be happy or efficient in such work. The AAT found that this kind of work would be reasonable for a person with the applicant's skills, qualifications, and experience to undertake.
> ***Re Tinkler*** (8 July 1997).

If the applicant has an accepted psychological disorder that would affect their capacity to undertake 'low level' work, this could be taken into account in deciding whether the applicant has the *capacity* to do such work. It does not come into consideration when deciding whether such work might reasonably be undertaken by 'a person' with the applicant's skills, qualifications and experience.

If a veteran moves to an area of known low employment, does this exclude the person from meeting the 'alone' test?

It is necessary to understand the reason that the applicant moved. If the reason is related to the applicant's accepted disabilities, then this cannot be used as a reason why the applicant is not engaged in remunerative work (**s 24(2)(a)**) or is prevented from continuing the kind of work he was undertaking (**s 24(1)(c)**).[35]

If the move was not related to accepted disabilities, it will be necessary to determine whether the change in location plays any part in why the applicant is not engaged in work (**s 24(2)(a)(ii)**).

[34] *Repatriation Commission v Counsel* [2002] FCAFC 201, (2002) 122 FCR 476, 72 ALD 204, 18 *VeRBosity* 55.

[35] *Byrne v Repatriation Commission* [2001] FCA 1134, (2001) 33 AAR 410, 17 *VeRBosity* 83.

The applicant has not worked since his business failed. Does the failure of the business mean that the 'alone' test cannot be met?

If the reason for the failure of the business is related to accepted disabilities, the business failure might be evidence that it is the effect of accepted disabilities alone preventing the applicant from continuing to undertake the kind of work he was undertaking (**s 24(1)(c)**).

If the business failure was not related to accepted disabilities, the loss of a job for a non service-related reason does not mean that the person cannot meet the special rate tests. It is necessary to ask why the applicant has been out of work *during the assessment period*. If the applicant is not looking for work, but has effectively retired (ceased to engage in work – **s 24(2)(a)(i)**), it is relevant to consider whether the failure of the business was a factor in why the applicant is now out of work. If it is, then the person is deemed not to have suffered a loss of earnings (**s 24(2)(a)**).

The applicant has not worked for 8 years. Does that length of time out of work affect special rate prospects?

It might have an effect if the applicant worked in a specialised field or industry that required keeping up with technological or other work skill changes. If the applicant cannot readily re-establish required skills or obtain the relevant knowledge, this may count as a reason other than incapacity from accepted disabilities for why he or she is be prevented from continuing to undertake work the applicant was undertaking (**s 24(1)(c)**).

The applicant has reduced her hours of work per week from 30 to 16 hours because of her accepted disabilities. Can she qualify for the intermediate rate?

Unless she has had to stop undertaking a particular kind of work due to accepted disabilities, the applicant is not entitled to either the special rate or the intermediate rate. The test in **s 23(1)(c)** requires that the person be prevented from continuing to undertake remunerative work that the person was undertaking. A reduction in hours in such work does not meet the 'prevented from continuing' test.[36] If the person has had to give up some work of a different kind to the work she is continuing to do,[37] and the applicant cannot work more than 20 hours a week in any kind of work then she may qualify for the intermediate rate (**s 23(2)**).

The applicant has a hobby farm, which brought in income of about $2,000 per annum. He is now no longer able to do that work. Is this remunerative work, and is the loss of that income a 'loss' for s24(1)(c) purposes?

Remunerative work is defined as 'any remunerative activity'.[38] However, the work the person performed must be 'substantial and substantive'[39] and so

[36] *Wright v Repatriation Commission* 2005] FCA 7, (2005) 21 *VeRBosity* 18; *Haskard v Repatriation Commission* [2002] FCA 1493, (2002) 71 ALD 29, 18 *VeRBosity* 104.

[37] *Repatriation Commission v Graham* [2004] FCA 1287.

[38] Subsection 5Q(1), VEA.

[39] *Repatriation Commission v Butcher* [2006] FCA 811.

does the loss.[40] This hobby farm work might not meet the requirements of being remunerative work that the person was undertaking (**s 24(1)(c)**). But that is not the end of the matter. It needs to be asked, what the applicant was doing before he started the hobby farm. If he had to give up that earlier work because of accepted disabilities alone (**s 24(1)(c)**), and would still have been undertaking that work were it not for accepted disabilities, then the special rate might be payable.[41]

The applicant has had a small business for many years, but the taxation records reveal that it has never made any profit. She has had to give up that business due to accepted disabilities. Has she had a loss of earnings on her own account?

Provided the applicant had access to the income of that business for her own benefit, the fact that the business never made a profit does not mean that she has not had a loss of earnings (**s 24(1)(c)**).[42]

Her loss of access to the income stream is a loss of earnings. The amount of income that she had access to might be relevant if it was a very small hobby-type business and could not be said to be 'substantial work' or a 'substantial loss'.[43]

The applicant has been looking for jobs in newspaper advertisements and has registered with an employment agency. Is this genuinely seeking to obtain work?

It can be. While there will usually be some objective evidence of seeking work, there need not be. One must consider the person's situation in a realistic way. If the person would take a job if one were offered, and has taken some steps to seek work, the fact that accepted disabilities make it difficult to do much more than this does not mean that those attempts were not genuine (**s 24(2)(b)**).[44] The attempts to find work must have been taken during the assessment period.[45]

The applicant took a redundancy and has not worked since. Has he ceased to engage in remunerative work for a reason other than accepted disabilities?

A person might leave a particular job for any number of reasons, but this will not necessarily preclude them from the special rate. The reason for not being engaged in work during the assessment period might not be the same reason that the person left their last job.[46] If the person took a redundancy with the intention of going to some other employment, but accepted disabilities intervened to prevent the person doing so, then taking a voluntary redundancy is not the reason the person has ceased to engage in work (**s 24(2)(a)**).

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[40] *Starcevich v Repatriation Commission* (1987) 18 FCR 221, 76 ALR 449, 7 AAR 296, 3 *VeRBosity* 163.

[41] *Starcevich v Repatriation Commission* (1987) 18 FCR 221, 76 ALR 449, 7 AAR 296, 3 *VeRBosity* 163.

[42] *Counsel v Repatriation Commission* [2002] FCAFC 201, (2002) 122 FCR 476, 72 ALD 204, 18 *VeRBosity* 55.

[43] *Repatriation Commission v Butcher* [2006] FCA 811; *Starcevich v Repatriation Commission* (1987) 76 ALR 449, 3 *VeRBosity* 163.

[44] *Hall v Repatriation Commission* (1994) 33 ALD 454, 10 *VeRBosity* 53.

[45] *Leane v v Repatriation Commission* [2004] FCAFC 83, (2004) *VeRBosity* 24.

[46] *Banovich v Repatriation Commission* (1986) 69 ALR 395.

Alternatively, the redundancy might have been used by the employer to remove an employee who was unproductive. That failure to perform at work might have been due to accepted disabilities. This might mean that the person ceased to engage in work due to accepted disabilities (**s 24(2)(a)**).

The applicant was injured at work and this was one of the reasons he left that work. He has not worked since. Medical evidence indicates that this injury is no longer significant, but that accepted disabilities are the cause of the incapacity for work. Can he meet the special rate tests?

It is necessary to consider the person's situation during the assessment period, not at the time he left his last job. If the applicant would have been able to continue to undertake the kind of work he had been undertaking when those work injury effects ceased, but it was then the accepted disabilities alone that prevented him from doing so, the 'alone' test may be met, and the veteran might not be taken to have ceased to engage in work during the assessment period for some other reason.

However, if the work injury played a role for some time in the applicant's capacity to work, it might be that being out of work for that time has caused him to lose the relevant skills and expertise and attractiveness to a prospective employer necessary for him to have gone back to work when the physical effects of the work injury ceased. If so, the work injury continues to have an effect on his capacity to undertake work after the physical effects of the injury have ended, and it will continue to be a reason for not meeting the 'alone' test.

The applicant worked as a plumber from age 34 to 69. He gave up that work due to war-caused disabilities alone. Does it matter that when he was aged 66 he sold his plumbing business to his son and then worked for his son for the last 3 years?

It might affect his eligibility for the special rate depending on the capacity in which he was working in his last paid work and during the last 10 years of his working life (**s24(2A)(g)**). It is first necessary to decide the capacity in which he did his last paid work:

- If he was an 'employee' in his last paid work, then to be potentially eligible for the special rate of pension he had to be an employee for the same employer or a predecessor of that employer for the last 10 years of his working life and before he turned 65. That is unlikely to be the case if he ran his own business before working for his son.
- If he was self-employed in his last paid work, then he had to be self-employed as a plumber for the last 10 years of his working life and before he turned 65.

Even though he last worked for his son, he might still meet the tests for being self-employed (for example, if he used his own tools and equipment, determined his own working hours, was paid by results rather than by time, work was not guaranteed, exercised his own skill and judgment, and could delegate work to someone else).[47]

[47] *Stevens & Gray v Bodribb Sawmilling Co Pty Ltd* (1986) 160 CLR 16.

Administrative Appeals Tribunal

Roncevich v Repatriation Commission

Downes J, President,
Hack, Deputy President, Ermert, Member

[2006] AATA 660
26 July 2006

Knee injury – fall from window – whether defence-caused

In 2001, the AAT affirmed the rejection of Mr Roncevich's claim that his knee injury was related to his defence service due to a fall from his barracks window.[48]

Mr Roncevich successfully appealed that decision to the Federal Court,[49] which remitted the matter to be reheard. On rehearing, the AAT again affirmed the decision,[50] which was appealed unsuccessfully to the Federal Court[51] and then to the Full Federal Court.[52] An application for special leave was granted by the High Court to appeal that decision,[53] and in 2005 the High Court granted the appeal and remitted the matter to be reheard by the Tribunal.[54]

Facts

In February 1986, Mr Roncevich attended a function in the Sergeant's Mess at Holsworthy. In the course of the evening he drank a quantity of beer, such that by the time he left the Mess to return to his room he was affected by alcohol. He intended to change into civilian clothes, iron his uniform for the next day and then return to the mess.

After reaching his room, he undressed and felt the need to spit, so he went to the window, stood on a trunk, lent forward to spit, overbalanced, and fell out of the window.

He was taken to his bed, and was medically examined the next day, at which time he complained of pain in his back. The following day, his back was still painful and he also complained of pain in his knee.

Two months later, arthroscopic examination revealed a peripheral tear to the posterior middle third of the lateral meniscus.

He returned to full duties a few months later, following which did some 49 parachute jumps, frequent route marches, physical training, and play rugby on a regular basis.

In 1997, Mr Roncevich made his claim for pension for a left knee condition, subsequently diagnosed as internal derangement of the left knee.

[48] (2001) 17 *VeRBosity* 6.

[49] (2001) 17 *VeRBosity* 88.

[50] (2002) 18 *VeRBosity* 33.

[51] (2002) 18 *VeRBosity* 106.

[52] (2003) 19 *VeRBosity* 56.

[53] (2004) 20 *VeRBosity* 152.

[54] (2005) 21 *VeRBosity* 105.

Diagnosis

In the previous AAT proceedings, the Commission had conceded that Mr Roncevich suffered from internal derangement of the left knee. However, on this occasion, it sought to introduce new evidence that showed that he was not, in fact, suffering from that condition. Mr Roncevich opposed the introduction of such evidence but the AAT allowed it on the basis that:

> [22] … the Tribunal exercises administrative power, albeit according to the judicial model. Its task is to determine the correct or preferable decision on the basis of all the material available. It is not bound by the rules of evidence nor is it governed by the Evidence Act. …
>
> [25] … Despite reaching that conclusion we should observe that the respondent's approach in withdrawing an earlier concession is not the type of approach that the Tribunal expects of the executive branch of government, *a fortiori* when it is done a very short time before the hearing.

On the medical evidence before it, the Tribunal considered that Mr Roncevich had suffered from three pathologies: a torn lateral meniscus, a degenerate tear of the medial meniscus, and a chronic anterior cruciate ligament tear, each of which came within the meaning of 'internal derangement of the knee' as defined in that Statement of Principles. The AAT found that this was the proper diagnosis of the claimed disability.

As Mr Roncevich claimed that he suffered from osteoarthrosis of the knee, the Tribunal considered whether the evidence indicated that he also suffered from that condition. It found that the relevant SoP required each of the factors in the definition to be present. The SoP defined osteoarthrosis as a clinical joint disorder associated with all the following factors:

- progressive loss of articular cartilage;
- sclerosis of the underlying bone;
- proliferation of bone and cartilage at the joint margins;
- inflammation of the synovium, and
- a history of pain, impaired function and stiffness

The Tribunal found that not all of these factors were present, and so found that Mr Roncevich did not suffer from osteoarthrosis of the knee.

Connection with service

In considering whether the fall from the window was connected with Mr Roncevich's service, the AAT said:

> [42] … Whilst in camp the normal duties of a SNCO would finish up around 4pm. At the end of normal duties the SNCOs would gather … 'to discuss unit matters over a beer'. The evidence of all the SNCOs was to the effect that gatherings of this nature were very important to the proper functioning of the battalion. They enabled participants to exchange information that was relevant to their task as SNCOs. …
>
> [45] There was no order requiring Mr Roncevich to attend the mess and there was no requirement that he drink the amount of beer that he did. But there was plainly an expectation that

the applicant and the other SNCOs would attend the Sergeants' Mess each afternoon and, equally, an expectation that the applicant, as a living-in member on the Base would attend a function put on at short notice for any visiting dignitaries.

[46] The applicant's evidence that it was a general requirement of the RSM that living-in members attend the mess every evening unless there was a conflict with other duties was not challenged. The evidence of the RSM at the time, Mr Colin Lee, that all living-in members were required to attend the function on the evening of 25 February 1986 was also not challenged. …

[52] … The evidence of Mr Roncevich was that he drank between six and eight cans of full strength beer. That beer would have been consumed in a period of about four hours prior to Mr Roncevich returning to his quarters …. Mr Roncevich describes himself as being intoxicated. He said:

> ... if I was to drive a car I would be over the limit but I still probably felt that I may have had control of my facilities [sic] and myself.

[53] The respondent submitted that Mr Roncevich was not required or expected to drink alcohol to this extent and that he did so as a matter of his own personal choice. Reliance was placed upon the evidence of Mr Thompson that the amount of alcohol consumed was a matter of individual choice. So much may be accepted and, indeed, Mr Roncevich accepted that he was not forced into drinking to the point where he became intoxicated. But the key lies in this answer that he gave:

> Sir, the policy comes out and it says certain things will be done, and certain things don't. And one is that, I believe it was expected of me, because I lived in a mess, to partake of drinks with the RSM downstairs. The RSM, at that stage, drank at a rapid rate. He drank a lot and I assumed it was my responsibility to keep up with him. And I did that. So I'm just saying that was what I felt was expected of me. And I think other sergeants probably felt exactly the same.

[56] Whilst we accept that Mr Roncevich was not required as a matter of duty to drink to the state where his faculties were impaired, we are well satisfied that there was an expectation that he would drink and do so quite heavily by the standards of today. No doubt the position is quite different in the Army at present with the greater recent awareness of the dangers of alcohol abuse. However we are of the view that in 1986 Mr Roncevich drank because he was expected to do so and because he was expected to keep pace with his RSM, Mr Lee. The critical events in this case occurred more than 20 years ago. We would be surprised if the expectations that we have found to exist at that time continued to exist in the culture of the present-day Army.

[57] By the time Mr Roncevich returned to his quarters he was affected by alcohol. That caused him to do at least two things that he would not have done had he not been so affected – spitting out of the window (rather than in the bathroom) and climbing on his trunk to do so.

[58] Mr Roncevich readily agreed that it was wrong of him to spit out the window. We accept that in ordinary

circumstances he would not have done so. Similarly, Mr Roncevich accepted that it was risky to stand on the trunk in order to lean out of the window. But we consider that he did these things, which led to him overbalancing and falling out of the window, because he was affected by alcohol. Having made unwise decisions his impaired balance and reaction time only made matters worse.

[59] It follows that we consider that the fall … attributable to Mr Roncevich's defence service.

Time of onset of signs and symptoms

Unlike the SoP for osteoarthrosis, which required certain signs and symptoms within 24 hours of the relevant trauma, the SoP for internal derangement of the knee required the relevant 'pain and swelling of the knee' to occur within 2 hours of the trauma. The Commission argued that the evidence did not support the 2 hour time element being met. The AAT said:

[71] … It is true to say that Mr Roncevich did not expressly make reference to pain and swelling in his left knee during that period, rather, he spoke of what seemed to him to be the cause of his pain, his back. However it seems to us to be unnecessary that there be evidence from the person concerned that there were subjective feelings of pain. Moreover it seems to us to be impossible for there to be any objective evidence of swelling within the 2 hour period unless there happened to be very prompt medical attention.

[72] But there is evidence that satisfies us, and that we do not regard as being 'problematic', that Mr Roncevich experienced pain and swelling in his left knee within two hours immediately following the fall from the window. That oral evidence comes from Dr Millons who would have expected him to have suffered left knee pain within 2 hours of the fall and who would have expected that his back pain would have masked any pain from the knee. It is inconceivable that Mr Roncevich could have suffered a lateral meniscus tear (at least) without there being any pain associated with that injury. Plainly the pain was masked by the injury to Mr Roncevich's back. Moreover, as Dr Millons said, the process of effusion or swelling that was noticed in Dr Hutton's examination of 27 February 1986 could be expected to have started at the time of the trauma.

Knee injury defence-caused

The AAT found that Mr Roncevich's internal derangement of the knee was defence-caused, saying:

[93] It is accepted that each of the three pathologies – the lateral meniscus tear, the medial meniscus tear and the anterior cruciate ligament tear – answers the description of internal derangement of the knee in the relevant Statement of Principles. On the medical evidence they are related and arise from the fall from the window in February 1986. Mr Roncevich suffered a twisting or wrenching injury to the left knee. There was pain and swelling of the knee within 2 hours of that fall even if that pain was masked by the greater pain experienced from his back injury. Internal derangement of the knee constituted by the lateral meniscus tear was detected clinically within six months of the fall. The Statement of Principles is satisfied.

Bachelor v Repatriation Commission

Ermert, Member

[2006] AATA 615
11 July 2006

Alcohol abuse – epilepsy – Ferriday shooting incident – whether a hypothesis raised

Mr Bachelor enlisted in the Army in 1968 and served as a canteen attendant. At that time he started to drink regularly. In 1970 he served in Vietnam as a canteen attendant and continued drinking.

On Christmas Day 1970 he heard three shots fired from within the lines of the base at Nui Dat. He rolled off his bunk, took his rifle and crawled outside his tent. A few minutes later he went back to his bunk and went to sleep. The next day he found out that the shots he heard were fired by Private Ferriday and had killed two and wounded a third sergeant in the Sergeant's Mess.

In January 1971, while still in Vietnam, he suffered a fit, subsequently diagnosed as an epileptic fit.

He claimed that his alcohol abuse an epilepsy were war-caused.

Alcohol abuse

The AAT found that although there was evidence pointing to Mr Bachelor experiencing the shooting incident, there was no evidence to connect that incident with Mr Bachelor's alcohol abuse.

In his evidence Mr Bachelor said that he had been drinking a dozen cans a day before going to Vietnam, and while initially he said his habit 'didn't change', upon further questioning he said it got 'a little worse over there'. He said that beer was readily available and cheap in Vietnam.

The Tribunal said:

> [27] The material before me points to Mr Bachelor's alcohol abuse starting after joining the Army and being posted to canteen attendant duties. This occurred in Australia and prior to his operational service in Vietnam. If there was a change in his drinking it occurred after Mr Bachelor's arrival in Vietnam, some eight months before the Ferriday incident. There is no material that points to a causal or temporal connection between his alcohol abuse and the incident.

Notwithstanding that the Tribunal found that the evidence before it did not raise a hypothesis of a connection with service, it went on to consider the relevant SoP for 'completeness'. The AAT said:

> [36] There is no suggestion that Mr Bachelor was present at or witnessed the shooting. The question remaining is whether he encountered or was faced with the event. … Even though he did not know at the time exactly what had happened, the sound of shots in the general area of the tent lines was sufficient for him to react for his immediate safety. Under these circumstances it could be said that Mr Bachelor did encounter or was faced with the event, being the Ferriday shooting.

> [37] The next element of the definition of 'severe stressor' is that it 'involved actual or threat of death or serious injury'. The Ferriday shooting resulted in the death of two sergeants and the serious wounding of a third. This element is clearly satisfied.
>
> [38] The last element is that the stressor 'might evoke intense fear, helplessness or horror'. …
>
> [39] … rifle shots are, by the very nature of lethal weapons, associated with death or serious injury. I find it quite conceivable that the sound of rifle shots coming from the near vicinity of one's tent lines might well evoke strong emotions such as intense fear, helplessness or horror. Whether the event did evoke such emotions is not for consideration at this stage of the process.

The AAT then considered the timing of clinical onset or worsening of alcohol abuse, and found that there was no evidence to point to onset or worsening after the shooting incident. The evidence pointed to its onset before the shooting. While Mr Bachelor said that he and others became very drunk the night of the shooting, this did not point to any change in his already well-established pattern of drinking. Therefore neither the factor relating to clinical onset or the factor relating to clinical worsening were met.

Epilepsy

Mr Bachelor relied upon his alcohol abuse as causing his epilepsy, or else the inability to obtain appropriate clinical management as aggravating his epilepsy.

As the AAT could not connect the alcohol abuse with service, that hypothesis failed.

In relation to the inability to obtain appropriate clinical management, the AAT found that there was no evidence that his epilepsy was aggravated, therefore that factor could not apply.

Decision

The AAT affirmed the decision under review rejecting the claims for pension from alcohol abuse and epilepsy.

Editor: This case shows that more is required for a claim to succeed based on experiencing a stressor than evidence that the person experienced the stressor.

There must be:

- **evidence establishing the diagnosis of the claimed condition;**
- **evidence pointing to the time of clinical onset or clinical worsening within or at the time required by the factor;**
- **if worsening is alleged, there must be medical evidence of the clinical worsening of the condition;**
- **evidence from a psychiatrist or clinical psychologist supporting the person's hypothesis that their experience of the stressor caused or aggravated their condition.**

Roberts v Repatriation Commission

Carstairs, Member

[2006] AATA 631
17 July 2006

Anxiety disorder due to a general medical condition – exposure to asbestos – pleural plaques – atrial fibrillation

Mr Roberts claimed that his anxiety disorder was due to suffering from a respiratory condition and a heart condition said to be due to his operational service in the Navy. He served in the Navy between 1959 and 1968 and in that time had rendered 153 days of operational service in a series of short periods in waters off Malaya, Singapore and North Borneo.

Diagnosis

The Tribunal considered conflicting psychiatric evidence on diagnosis and preferred that of two psychiatrists who diagnosed 'anxiety disorder due to a general medical 'condition rather than the opinion of one who diagnosed generalised anxiety disorder.

Respiratory conditions

In 1993, Mr Roberts was diagnosed as having mesothelioma, which the Repatriation Commission accepted as war-caused. Subsequently it was found that this diagnosis was incorrect and the decision accepting it was revoked. Instead, he was diagnosed as having pleural plaques, which was accepted as war-caused. For the purposes of this claim, the Commission conceded that pleural plaques and atrial fibrillation were war-caused.

The applicant's evidence

The Tribunal said:

> [23] Mr Roberts told me that he is concerned for his future as he believes that his pleural plaques will develop inevitably into asbestosis and later to mesothelioma. He said that x-rays now have confirmed that he has mild asbestosis. When he was first diagnosed with pleural plaques his general practitioner phoned him and told him to come in urgently. Mr Roberts said he was shattered with the diagnosis. An appointment was made to return to the specialist, but this took some 3 or 4 weeks. The specialist assured him that he did not have more sinister developments, but Mr Roberts firmly believes his prognosis is poor. He said that the time frames for worsening of the disorder as he understood it were 15 to 20 years and he is conscious that his diagnosis was made 13 years ago. This is a cause of great ongoing anxiety to him.
>
> [24] I noted that his general practitioner's clinical notes of his attendances … recorded in 1993 that x-rays raised the question of mesothelioma and therefore great anxiety; in 1994 he had counselling sessions for anxiety; in 1996 that he had whole consult re asbestos exposure.
>
> [25] Mr Roberts said that he is conscious of several deaths involving asbestos-related diseases including that of one colleague who served with him on HMAS *Melbourne*. He said that he finds it devastating to watch coverage of the

issue on television and referred to the panic attacks he experiences about death from this disease.

[26] Mr Roberts said that he suffers anxiety about his atrial fibrillation as well. He said that he has recorded heart rates of 200 per minute on 5 occasions and has been hospitalised for this. He believes he has been in life threatening situations because of it.

Evidence supporting the hypothesis

The Tribunal then addressed the medical evidence supporting the hypothesis and said:

[27] The evidence of two psychiatrists in this matter, as outlined above, was that Mr Roberts' medical conditions are the direct physiological cause of his anxiety. …

[30] … Dr Hewland stated that Mr Roberts' severe anxiety symptoms arose directly from his generalised medical conditions of digestive, respiratory, cardiovascular and hearing problems which arose from his war service. She noted that he was increasingly frustrated and helpless from the symptoms of his physical disorders and worries about early death. She noted his fear of choking while asleep because of his reflux and chronic obstructive pulmonary disease. Not all these conditions are accepted as due to Mr Roberts war-service, and I have taken that matter into account in reaching my conclusions. However it is safe to conclude that Mr Roberts is a person who reacts badly to his declining health.

[31] Dr Radovic stated that Mr Roberts had anxiety and panic attacks with some obsessive compulsive features and that his symptoms arose directly from his generalised medical conditions that were respiratory, digestive and hearing-related and arose from war service. He stated that the recent diagnosis of atrial fibrillation only worsened Mr Roberts' anxiety symptoms.

[32] The respondent's submissions imply rather than state that it was not objectively reasonable that Mr Roberts should react to his accepted disabilities in the manner that he states, and/or that his reactions in truth are to medical conditions that are not accepted as war-caused. In particular, Mr Kelly submitted that the respiratory problems that Mr Roberts suffers arise from asthma not from the effects of pleural plaques. He submitted that his atrial fibrillation is well-controlled by medication. Mr Kelly says that Mr Roberts' unfounded perceptions of his prognosis are the stressors that give rise to his anxiety and that I should accept Dr Gold's diagnosis and conclude that Mr Roberts does not suffer from anxiety disorder due to a generalised medical condition.

The AAT then said:

[33] … Under s120(1), the hypothesis will be established unless facts necessary to support the hypothesis are disproved or other facts are proved that are inconsistent with those raised by the hypothesis. In regard to the fourth step in *Deledio*, pursuant to s120(1) I am not satisfied beyond reasonable doubt that there is no sufficient ground for determining that Mr Roberts' anxiety is war-caused. I accept his evidence as truthful: it is uncontradicted by other evidence; and it is supported by those medical practitioners who are in the best position to know, that is his treating psychiatrists. I do not see Mr Roberts'

concerns as unfounded, especially in the context of medical evidence that he is predisposed to react in the way that he does.

[34] As the Federal Court stated in *Repatriation Commission v Crane* [2004] FCAFC 86, although in comment upon a different factor in the Statement of Principles:

> … if a reasonable hypothesis of a relationship between pleural plaques and exposure to asbestos dust during operational service is accepted (as it has been), it is not a difficult step to find that there is a reasonable hypothesis of a relationship between an anxiety disorder about asbestosis and exposure to asbestos dust during operational service.

[35] Because Mr Roberts' hypothesis is pointed to by the evidence and is not excluded beyond reasonable doubt it follows that Mr Roberts' anxiety disorder is war-caused within the meaning of s9 of the Act.

Decision

The AAT set aside the decision under review, accepted anxiety disorder and remitted the assessment of pension to the Commission.

Editor: The AAT did not consider whether pleural plaques was war-caused as this was conceded by the Commission for the purposes of the anxiety disorder claim. If this had not been conceded, the AAT could not rely on the previous acceptance but would have had to address the issue itself: see *McKenna's* case.[55]

[55] *McKenna v Repatriation Commission* [1999] FCA 323, (1999) 29 AAR 70, 15 *VeRBosity* 22.

Harmer v Repatriation Commission

Bell, Senior Member

[2006] AATA 663
28 July 2006

Death – carcinoma of prostate – fat intake – effect of basal metabolic rate (BMI) on metabolism of fat

Mrs Harmer claimed that her late husband's death in 1990 from prostate cancer was war-caused. Mrs Harmer married her husband 3 years before he enlisted. He served in the Army during World War 2 and rendered operational service in the South West Pacific Area. In 1987 Mr Harmer was diagnosed with prostate cancer.

Mrs Harmer contended that her husband's prostate cancer and death was contributed to by his service diet. The AAT said Mrs Harmer gave evidence that:

> [11] … Mr Harmer returned from service a changed man and that he was irritable, had begun to drink and smoke heavily and expressed a negative attitude to his service experiences and their commemoration. She said, in answer to questions asked by Dr Volker, that on his return from service he developed a liking for sugar, condensed milk, cake, biscuits, ice cream, bacon and eggs and food fried in dripping. I also note the evidence of Dr Volker that stress can cause people to eat 'comfort foods', typically the foods they grew up with and, particularly in relation to veterans, condensed milk.

The AAT found that this gave rise to a hypothesis that stress related to service contributed to a high fat diet that contributed to prostate cancer and to the veteran's death, and that the hypothesis was reasonable as it was upheld by the Statement of Principles, which required an increase in animal fat consumption by at least 40% and to at least 50gm/day, and maintaining these levels for at least 5 years within the 25 years before the clinical onset of prostate cancer.

Whether the hypothesis was disproved

The Commission contended that Mr Harmer's alleged level of consumption of animal fat could not have occurred.

Dr English gave evidence that Mr Harmer's post-war fat consumption could not be 'validated' and was a 'gross over reporting' because, in her view, the reported food intake would have produced a weight increase of 0.8 kilograms per week and such an increase did not occur. She reached that view on the basis of calculations using a certain assumed activity level and a certain assumed basal metabolic rate (BMR).

Dr Volker, on the other hand, was of the view that while there was some over reporting by Mrs Harmer, Mr Harmer's possible activity level and BMR as affected by a range of matters including bouts of malaria, smoking and his lean body mass, made the contended increase in fat consumption possible.

Calculation of the veteran's BMR

The Tribunal noted that:

> [21] … each of the experts uses a different formula to estimate BMR. Dr Volker uses a computer program called 'Foodworks' which is an amalgam of 3 equations, including the 'Schofield' formula while Dr English uses the 'Schofield' formula alone. Each expert was critical of each other's method. Dr English said the 'Foodworks' program is contrary to the 'recommendations of expert national and international bodies'. Dr Volker said the 'Schofield' formula is a formula used for populations and uses age ranges that are too wide to accurately assess individuals.
>
> [22] According to medical and service records, Mr Harmer's weight on enlistment was 9 stone. His weight, three years later, just prior to discharge was 9 st 6 lbs. His post war weight fluctuated but remained above his weight on enlistment. The next record of his weight is in September 1963 when he was 10 st, then 11st 11lb in May 1965 and then 3 months later he was 12st 8lbs. Eleven years later he lost 2 st in 18 months and was 10 st 4 lbs in April 1978 and finally 9 st 10 lbs in January 1979. I also note Mrs Harmer's evidence that after the war Mr Harmer's trouser size increased and he put on weight.
>
> [23] As to Mr Harmer's activity level, Mrs Harmer's evidence was that Mr Harmer returned to work as a painter after the war. Her evidence was also that he became a foreman 'for the last 18 years of his working life'. Mr Crowe has this change to the position of foreman taking place in 1962. Mr Karp

submits that, given Mr Harmer turned 65 in 1982, then he would have begun as a foreman in 1964. It was also submitted by Mr Crowe that, as a foreman, Mr Harmer would have had a lower activity level. Mr Karp noted there was no evidence to this effect, except for Mrs Harmer's evidence that Mr Harmer put on weight over this period. I agree that it is impossible to accurately assess his activity level at this time. I also note that both experts agreed that the measurement of activity levels is inexact. Dr English conceded that it requires the use of predictive equations 'doing the best we can' with data from Mrs Harmer and from available scientific data.

[24] In relation to BMR, Dr Volker's evidence was that, between individuals, BMR may vary as much as 60 to 80 %. She based this view on her knowledge from clinical research and an understanding of the effect of a range of variables on metabolic rate. By contrast, Dr English's evidence was that an individual's metabolic rate could vary by up to 17% from the mean. She reached this view on the basis of her knowledge of the relevant literature.

[25] Dr Volker said:

> As far as metabolism is concerned, there are a number of factors that effect markedly one's metabolism or metabolic rate and that is age, body shape, size, lean body mass, gender, climate, pregnancy, illness and the specific thermodynamics of food, and then you could put in cultural factors, so there are nine – nine effects there – and you can put in particular drugs – so 10 factors that could affect the metabolism of an individual. (transcript, p.38)

[26] Dr English, when asked about the factors that might produce a change in BMR, said that age, weight and sex are the three factors that feature in the predictive equations.

[27] An additional factor acting on metabolic rate is cigarette smoking. Mrs Harmer's evidence was that whereas prior to service Mr Harmer smoked only occasionally, by the late 1950's he was smoking 2 packets per day. Both experts agreed that smoking raises BMR but neither put a figure on it. However, I note that, in their analysis, neither expert factored in smoking.

[28] Finally, it is common ground that Mr Harmer suffered from recurrent bouts of malaria. Mrs Harmer's evidence was that when he had a bout of malaria he would shiver so as to make the bed rattle and would perspire profusely. She said this happened many times 'for years and years' and petered off as he got older but he would still have small attacks. She said attacks would last from a few days to more than five days and sometimes he would need hospitalisation. In all cases he would be bedridden. Dr Volker considered that an episode of malaria will increase BMR by 10%. I note that an article entitled 'Insights into energy requirements in disease' (Elia, Marinos in *Public Health Nutrition*, Vol. 8 Number 7(A), October 2005) indicates that a persistent fever will increase BMR by between 20% and 30% (Exhibit R4). However, I have only Mrs Harmer's recollection of the frequency and duration of the bouts of malaria. Depending on that frequency and

duration, they may have had a significant impact on Mr Harmer's BMR. It may also be the case that they had, as Dr English said, the effect of decreasing activity level while Mr Harmer was bedridden but I note she allowed that Mr Harmer's shaking would impact on his activity level.

[29] Ultimately I cannot be satisfied, beyond reasonable doubt, what Mr Harmer's BMR was and therefore what its effect was on the possibility of the fat consumption hypothesised. The range of matters unknown, including those concerning Mr Harmer's BMR (as affected by smoking, malaria and lean body mass) and his activity level (as affected by work activity and the effects of malaria) prevent me from being satisfied, beyond reasonable doubt, on the basis of Dr English's opinion, that Mr Harmer's fat consumption was not at the level required by the SoP. It follows that I am not satisfied, beyond reasonable doubt, that Mr Harmer's death was not war caused.

Decision

The AAT set aside the decision under review and determined that Mr Harmer's death was war-caused.

Dor v Repatriation Commission

Hack, Deputy President

[2006] AATA 767
8 September 2006

Dismissal of VRB application – failure to provide response to s155AA notice – response claimed to have been posted – whether response provided in required manner

On 16 May 2003 Mr Dor sought review by the Veterans' Review Board of a Repatriation Commission decision. On 3 September 2003 the Board sent Mr Dor (with a copy to his representative) a letter seeking the lodgement of a Certificate of Readiness or advice on when the application would be ready for hearing. The representative telephoned the Board the following day and advised that he was 'still gathering evidence'. Similar letters were sent by the Board on 24 February 2004, 23 August 2004 and 22 February 2005.

By 19 May 2005 more than two years had elapsed from the date of receipt of the application to the VRB, and so the Registrar, as delegate of the Principal Member of the Board sent to the applicant a written notice under s 155AA(4) requesting Mr Dor to provide, within 28 days after receipt of the notice, a written statement indicating that he was ready to proceed at a hearing or a written statement explaining why he was not ready to proceed.

On 24 May 2005 the representative telephoned the Board and advised that Mr Dor was 'awaiting another claim'. The VRB staff member advised him that the response to s 155AA notice had to be provided within the 28 days as required by the notice.

The Board did not receive anything from the applicant, and on 1 July 2005 the application was dismissed.

Mr Dor applied to the AAT for a review of the dismissal of his VRB application on the ground that his representative had sent a response to the Board on 3 June 2005 (prior to the expiry of the period of 28 days). Accordingly, Mr Dor contended that he complied with s 155AA(5) by providing a written statement under s155AA(4)(d) and the Board was wrong to dismiss his application.

Meaning of 'provide'

The Tribunal discussed the meaning of the word 'provide' as follows:

> [11] In *Nair v Minister for Immigration and Multicultural Affairs* the Full Court of the Federal Court was called upon to consider s 312(2) of the *Migration Act 1958* (Cth). That section required a registered migration agent to 'provide to the [Migration Agents Registration] Board' certain information. That step followed notification from the Board to the agent pursuant to s 301 of the need to renew the registration. The Court at [40] concluded that:
>
> > ... the estimate required by s 312(2)(c) of the Migration Act is 'provide[d] to the Board' if the agent concerned supplies the information in the manner specified in the notification given by the Board to the agent in accordance with s 301.
>
> [12] Given the parallels between the legislation in issue in that case and s 155AA of the Veterans' Entitlements Act it seems to me that I should give an equivalent meaning to 'provide' in the present case. Thus, in my view, the critical question, where I am satisfied that the written statement was not received by the Board, is whether it was 'provided' to the Board in this sense, despite the non-receipt.
>
> [13] The letter of 19 May 2005 required the applicant to provide a written statement informing the Board that the applicant was ready to proceed or, if not, reasons why the matter was not ready. It specified the manner in which that information could be provided – by completion of a signed Form 1 – and it specified two ways in which the completed document could be sent to the Board. It could be sent to the Board 'at the above address' or it could be sent using the prepaid envelope enclosed with the letter. The applicant says, in terms, that his representative supplied the information in the manner specified by posting it to the Board at P.O. Box 349, Brisbane, one of the addresses given in the letter.

Whether the response was posted

The Tribunal then discussed the evidence concerning whether the response was, in fact, posted to the Board.

> [14] The evidence of [the representative] does not satisfy me that that was, in fact, done.
>
> [15] … I must say that I find [the representative]'s evidence on the critical issues to be unreliable. He was vague about the details of his dealings.

He did not, initially, bring with him his file of his dealings on behalf of the applicant. The matter was stood down to enable him to retrieve the file. He was cross-examined further once he had produced the file. The file contained a document which, he said, recorded significant events from and following receipt of the Board's letter of 19 May 2005. The fifth entry says '3 JUN 05 Posted back back [sic] to VRB by D.S.' I am unable to accept his evidence that this entry was made contemporaneously with the events described. It seems to me, having regard to the content of the document, that it was more likely compiled after this matter became contentious. I do not accept [the representative]'s evidence to the contrary.

[16] [The representative]'s statement, Exhibit 2, was filed following a direction made on 11 August 2006 for the filing of witness statements relied upon by the applicant. It is almost entirely devoid of detail. It makes reference to a telephone conversation with a representative of the Board on 24 May 2005. The fact, and content, of that conversation is not in issue. It continues:

> The correspondence was posted on to the VRB on 3 JUN 05 in a Redlands RSL prepaid envelope.

[17] The 'correspondence' referred to by [the representative] was, he said, the completed Form 1 and Form 2. In his oral evidence [the representative] agreed that he had no particular recollection of what he had done on this occasion; his evidence was more about what he 'would have done' i.e. his usual practice. He was initially unable to recall whether he had received a copy of the letter of 19 May 2005 from the Board. Once he had retrieved his files he was able to produce a letter (Exhibit 7) marked in a way that satisfies me, having regard to the evidence of Mr Loftus, that he did receive a copy of the 19 May 2005 letter.

[18] Initially [the representative] said that he had received copies of the documents by facsimile from the applicant once the applicant had signed and dated them. The copy of the Form 1 produced by [the representative] shows that the applicant was not ready for a hearing and provides a reason for that. It was signed by the applicant and dated 25 May 2005. The balance of the handwriting on the document is acknowledged by [the representative] to be his writing. The copy of Form 2 is also signed by the applicant and dated 25 May 2005. Again [the representative] acknowledged that the balance of the writing (including the affixing of some rubber stamp impressions) was his. [The representative] signed that document on 3 June 2005.

[19] The documents produced by [the representative], and which he says were sent to the Board on 3 June 2005, bear no evidence of having been sent by facsimile. Had they been sent by the applicant in this way, as [the representative] claimed, it might be expected that that would have been evident from the markings that routinely appear on documents sent by facsimile. When asked about this [the representative] said that the applicant must have delivered the documents to him. That appears contrary to the notation in his 'chronology'.

[20] [The representative]'s evidence was to the effect that he 'would have' completed the details on the forms, handwritten the Board's post office box address on an envelope, gone to the [local sub-branch] RSL (where he was the Pensions and Welfare Officer) and put the envelope in the RSL's mailing system. He was thus even unable to say that the letter got into the postal system.

[21] The evidence leaves me far from satisfied that the Form 1 and the Form 2 were posted by [the representative] at all. In the result I am satisfied that the applicant did not provide a written statement under s 155AA(4)(d).

Decision

The AAT affirmed the decision to dismiss the VRB application.

Editor: This case highlights the need for representatives to carefully manage those cases that have gone beyond the two-year standard review period and are subject to dismissal action.

The case also indicates the value of maintaining a formal correspondence register that indicates the date and nature of all correspondence received and sent by the representative or their organisation.

The following table gives a summary of the dismissal provisions. Further information about these provisions can be found in the Handbook for Representatives, available from VRB Registries or on-line at www.vrb.gov.au.

Summary of the dismissal provisions

Section	Effect
155AA	A **s155AA(4) notice** is sent to the applicant if: • the application is more than **2 years** old; and • the application is not listed for hearing; and • the Registrar (as delegate of the Principal Member) thinks it should be ready to proceed. The application is dismissed if there is no response to the notice within **28 days** or the explanation for not being ready for a hearing is not reasonable. If the explanation is reasonable, an **extension notice** is sent.
155AB	**3 months** after the extension notice is sent a **s 155AB(4) notice** must be sent. The application is dismissed if there is no response to the notice within **28 days** or the explanation for not being ready is not reasonable. If the explanation is reasonable, another **extension notice** is sent.
155AC	Permits an applicant to **authorise a representative** to respond to ***a particular*** **s 155AA(4) notice** or **s 155AB(4) notice**.
155A	Enables application to the AAT (within **28 days**) if the VRB application is dismissed.

Federal Court of Australia

Brown v Repatriation Commission

Branson J
[2006] FCA 914
19 July 2006

'Kind of death' – terminal event – non-Hodgkin's lymphoma – procedural fairness

Mrs Brown's claim for a war widow's pension was based on a contention that a service-related smoking habit led to ischaemic heart disease, which then played a part in his death.

The death certificate had set out the causes of death as:

(I) (a) cardiorespiratory exhaustion, 1 week

(b) progressive non-Hodgkin's lymphoma, 9 months

(II) Sepsis (chest/urinary), 1 week

The AAT affirmed the rejection of her claim on the basis that the 'kind of death' suffered by the veteran was death from non-Hodgkin's lymphoma, and that no hypothesis could be raised on the material before it in relation to that kind of death that could be upheld by any of the factors in the SoP for that non-Hodgkin's lymphoma.

On appeal to the Federal Court, it was argued that:

- the AAT misunderstood the evidence of a medical witness in relation to the 'kind of death' suffered by the veteran;
- it should have characterised the 'kind of death' as including 'death from pneumonia-related infection'; and
- the AAT had denied the parties procedural fairness when it decided that the veteran suffered a 'kind of death' different from that put to it by the parties.

Whether a question of law

An appeal to the Federal Court under section 44 of the AAT Act must be on 'a question of law'. The Court rejected the first two grounds on the basis that they were not questions of law. The first ground involved the 'understanding' of the Tribunal, which the Court said could only be a question of fact. The second ground involved a mixed question of law and fact, and so could not be characterised as 'a question of law'.

The Court said that the third ground, as it concerned procedural fairness, it involved a question of whether there had been 'an error of law', but Branson J expressed the opinion that this did not necessarily mean that there was a 'question of law'. Nevertheless, Her Honour recognised that she was bound to follow a majority Full Court judgment in which such a matter had been held to be a 'question of law'.

Counsel for Mrs Brown sought to ensure that all legal errors could be included in the Court's consideration by seeking leave to amend the appeal notice to

include an application under the *Administrative Decisions (Judicial Review) Act 1977*, which enables a greater range of legal errors to be considered by the Court. However, Counsel failed to seek an extension of time to make such an application and had made no attempt to frame the proposed amendments in the proper form required by the Federal Court Rules. The Court rejected the application to amend the notice of appeal. Nevertheless, Branson J still considered the arguments raised by Counsel for Mrs Brown and addressed them in her judgment.

Whether death hastened by ischaemic heart disease

The Court said:

> [20] In its written reasons for decision the Tribunal accurately recorded that it was Dr Edwards' opinion that Mr Brown died of overwhelming sepsis, that non-Hodgkin's lymphoma had reduced Mr Brown's ability to fight infection and that treatment for that illness had similarly compromised his immune state …
>
> [21] The Tribunal summarised its understanding of Dr Edwards' evidence, and the conclusions to be derived therefrom, in the following passage from its reasons for decision:
>
> > As we understand Dr Edwards's evidence, the pneumonic infection was a complication of the non-Hodgkin's lymphoma and its treatment. This is not a case of multiple 'kinds of death'. Accordingly, we find that the kind of death suffered by Mr Brown was 'non-Hodgkin's lymphoma'. This is in accord with the clinical decision of the palliative care team taken three days before Mr Brown died, that his condition was incurable.
>
> [22] Mrs Brown, by her counsel, submitted that Dr Edwards' evidence was not to the effect that the sepsis was a complication of the lymphoma alone. In support of this submission counsel drew attention to certain answers given by Dr Edwards in cross-examination. During his cross-examination Dr Edwards said that ischaemic heart disease was a significant underlying disease process that Mr Brown had. He agreed that he might have included ischaemic heart disease in part 2 of a death certificate for Mr Brown; that is, in the section of the certificate which Dr Edwards described as appropriate for recording 'contributing factors, factors that might be in the background, present for many years'. He contrasted factors of that kind with 'causes of death'.
>
> [23] Dr Edwards was not asked in cross-examination, or it seems at any time, to express an opinion on whether, because of his ischaemic heart disease, Mr Brown died from pneumonia earlier than would otherwise have been the case. Nor was Dr Edwards asked to express an opinion on whether ischaemic heart disease otherwise accelerated Mr Brown's death. In the absence of answers from Dr Edwards on these questions, it is to be inferred from the answer recorded in [19] above, that Dr Edwards did not think that ischaemic heart disease accelerated Mr Brown's death.
>
> [24] The contention that the Tribunal misunderstood Dr Edwards' evidence is untenable. Dr Edwards' evidence was that the proximate or ultimate

cause of Mr Brown's death was pneumonia caused by sepsis originating in his lungs and urinary tract; Mr Brown was unable to resist that proximate or ultimate cause because of his rapidly progressive non-Hodgkin's lymphoma. Dr Edwards, for this reason, described non-Hodgkin's lymphoma as Mr Brown's underlying cause of death. While Dr Edwards accepted that Mr Brown suffered from ischaemic heart disease, nothing in his report or evidence provided support for a conclusion that Mr Brown's heart disease played a part in, or accelerated, his death from pneumonia.

Multiple kinds of death

The Court rejected the submission that the evidence required the Tribunal to find that the 'kind of death' was death from pneumonia-related infection. Branson J said:

> [30] The Tribunal was alive to the possibility that multiple medical conditions could have contributed to Mr Brown's death. It observed in its reasons for decision:
>
> > There can be multiple medical conditions that contribute to a particular death in the sense of a medical cause that expedited the death. If a medical condition contributed to the death and is relevantly related to service then that is sufficient to establish entitlement to pension (see *Hancock* [2003] FCA 711 at [8]-[9].
>
> [31] However, the Tribunal concluded that the kind of death met by Mr Brown was the kind of death in respect of which a Statement of Principles had been determined, namely the Statement of Principles concerning Non-Hodgkin's Lymphoma dated 12 August 2003. That Statement of Principles … is relevant to a death from a terminal event which was contributed to by the person's non-Hodgkin's lymphoma. It defines 'terminal event' to mean the proximate or ultimate cause of death including pneumonia, respiratory failure, cardiac arrest, circulatory failure or cessation of brain function. As discussed above, the Tribunal considered Mr Brown's pneumonia to have been a terminal event as that expression is defined in the Statement of Principles.
>
> [32] The above conclusion of the Tribunal has not been shown to have involved any error of law or otherwise to be amenable to review under s 5 of the ADJR Act. Indeed I respectfully suggest that the Tribunal's decision was manifestly reasonable having regard to the evidence and other material before it.
>
> [33] In the circumstances it is not necessary for me to give consideration to whether a veteran may meet more than one kind of death, as opposed to a death to which a number of medical conditions contribute, for the purposes of s 120A(4) of the Veterans' Entitlements Act.

Procedural fairness

In relation to the issue whether the AAT had denied the parties procedural fairness by finding a 'kind of death' different from that put to it by the parties, the Court referred to a number of exchanges in the transcript of the hearing that showed that the AAT had put both parties on notice that it might find that the relevant 'kind of death' was death from non-Hodgkin's lymphoma.

The Court rejected that ground of appeal. Branson J said:

> [35] … An administrative tribunal such as the AAT is not obliged to accept a submission put to it jointly by the parties to a dispute. The duty of the AAT is to make the correct or preferable decision in the circumstances (*Drake v Minister for Immigration and Ethnic Affairs* (1979) 24 ALR 577).
>
> [36] The … Tribunal let the parties know the approach that it proposed to take, and gave them an opportunity to be heard on whether it should find that the kind of death met by Mr Brown was pneumonia. The Tribunal could hardly have made it plainer that, if it concluded that pneumonia was simply a terminating event in Mr Brown's death, it was unlikely to find that he met a 'pneumonia kind of death'.

The Court's order

The Court dismissed the appeal and ordered Mrs Brown to pay the Commission's costs.

Editor: In *Spencer v Repatriation Commission* [2002] FCA 229 the Court held that if the RMA has not made a SoP about relevant the kind of injury, disease or death, then no SoPs apply to the entire chain of causation from service to the claimed injury, disease or death. It was this background that appears to have led to the argument in *Brown's* case that the kind of death was 'death from pneumonia-related infection' rather than death from non-Hodgkin's lymphoma.

In *Re Etheridge and Repatriation Commission* [1998] AATA 133, the President of the AAT held that if a person died from pneumonia, then that was their 'kind of death', and as the RMA has not made a SoP about pneumonia, no SoPs needed to be applied. In response to *Re Etheridge*, the RMA inserted a clause into all SoPs (since Instrument № 37 of 1998), defining 'death from' the particular injury or disease covered by the SoP. For example, the SoP concerning malignant neoplasm of the prostate provides that 'death from malignant neoplasm of the prostate includes death from a terminal event or condition that was contributed to by the person's malignant neoplasm of the prostate'. 'Terminal event' is then defined to mean the proximate or ultimate cause of death and includes, pneumonia, respiratory failure, cardiac arrest, circulatory failure, or cessation of brain function.

This means that when considering the 'kind of death', it is now necessary to look beyond the immediate cause of death. The decision-maker must have regard to the injuries or diseases that contributed to the 'terminal event', and not merely consider the terminal event in isolation.

If the hypothesis or contention raised by the material includes, say, service conditions leading to prostate cancer causing debility leading to pneumonia and then death, the 'kind of death' applicable to that hypothesis or contention is 'death from prostate cancer', and the SoP concerning 'malignant neoplasm of the prostate' would apply. It would be wrong in such a case to state that because the RMA has not made a SoP about 'pneumonia', then no SoPs apply.

Iversen v Repatriation Commission

Edmonds J
[2006] FCA 942
28 July 2006

Entertainer in Vietnam – whether a veteran – whether a representative of AFOF

Mr Iversen was a civilian who made four trips to Vietnam as a musician between 1967 and 1970. He was paid by the Australian Army for each of these tours and received allowances through the Army while he was on tour. One of the tours was jointly sponsored by the Army and the Australian Forces Overseas Fund ('the AFOF'). While individual entertainers on the tour were sponsored by the AFOF, the Sydney ABC Dance Band, of which Mr Iversen was a member, was sponsored on that tour by the Army.

The AAT affirmed the rejection of Mr Iversen's claim for disability pension on the ground that he was not a veteran. While the Minister for Veterans' Affairs had made an instrument deeming certain representatives of philanthropic organisations, including AFOF, to be members of the Forces for the purposes of the VEA, it held that Mr Iversen was not a 'representative' of AFOF.

It was argued that the AAT had misinterpreted the word 'representative'. The Court said:

> [15] The applicant, in his written submissions, contended that 'representatives' as it appears in the Determination should be given a meaning that protects those who were in fact in a war zone and thereby exposed to the risks and circumstances associated with that war. It was submitted that such a 'factual' emphasis on the meaning of representatives would accord with the beneficial nature of the Act and the Determination made under it. But such a construction goes well beyond the natural and ordinary meaning of the word 'representative' as exemplified in the dictionary meanings of the word upon which the applicant himself relies.
>
> [16] In his oral submissions, the applicant articulated what is substantively, albeit not in the same terms, a similar argument, namely that if the applicant's presence in the war zone is only explicable by reference to his participation in a concert tour co-sponsored by the AFOF and the Australian Army, then he can be a representative of the former. That might be so, but such co-sponsorship will not of itself make the applicant a representative of the co-sponsor. Indeed, as the respondent submits, even if the applicant had been an 'AFOF sponsored' entertainer rather than an 'Army sponsored' entertainer, being sponsored by an organisation cannot be equated with being a representative of that organisation.

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

Streatfield v Repatriation Commission

Cowdroy J
[2006] FCA 984
2 August 2006

'Kind of death' – motor vehicle struck and killed veteran – whether headache led to death

Mr Streatfield sustained concussion in 1942 during an air defence training exercise. Mrs Streatfield claimed that following his discharge from the Army in 1946 her husband suffered from headaches and dizziness which became increasingly intense. Mr Streatfield had occasionally needed to take time off work because of headaches, and not long before his death was suffering headaches very frequently causing a slight tremor of his head.

In 1976 Mr Streatfield died as a result of injuries sustained when he was struck by a passing motor vehicle as he was standing on the footpath. An inquest into his death found that Mr Streatfield had been standing beside the road with the apparent intention of crossing the road. He was struck by an eastbound van and was thrown onto a concrete footpath, sustaining a fatal head injury. It was found that a protruding rear vision mirror of the van was severely bent out of position after the accident.

The coroner considered that there were three possible causes of the accident: Mr Streatfield had either stepped off the footpath into the path of the moving van, slipped on the downward sloping grass verge into the path of the van, or had been standing on the gutter edge when he was struck by the protruding rear vision mirror of the van. The coroner considered that the less likely possibility was that the veteran had stepped out from the kerb into the path of the vehicle. However the coroner made no definitive finding as to how the accident occurred.

Associate Professor Corbett stated:

> 'Migraine headaches at their peak may result in the sufferer experiencing dizziness, including vertigo, disorientation and at times frank confusion. At the time of the veteran's fatal head injury his wife reports that he was experiencing frequent headaches with migraine characteristics. It is a reasonable hypothesis that migraine headache may have been a factor contributing to the veteran stepping off the kerb and suffering a fatal head injury and thus a significant factor contributing to his death.'

The AAT summarised the evidence of Professor Lance as follows:

> '[Professor Lance] also noted from his interview with Mrs Streatfield that she remembered the Veteran's saying, just before he left on the errand that led to his death, that he would be back early because they were planning to inspect a possible venue for a twenty first birthday party for one of their children. No mention was made of a headache at that time.'

In his written report Professor Lance stated:

> 'The history of Mr Streatfield's headaches is typical of migraine. I cannot find any evidence that he suffered from migraine during his war service. It appears more likely that migraine began early in the 1950s.
>
> The headaches were not associated with faintness or fainting and there is no evidence that he had a headache or was otherwise unwell before he fell or was struck by a vehicle in the fatal accident on 14 May 1976.
>
> ...
>
> I am unable to find any link between his tendency to migraine headaches and his death.
>
> ...
>
> I have read the reports of Professor Corbett and I agree that his hypothesis is possible but, for the reasons detailed above, I do not consider it probable.'

The AAT noted that both Professors Corbett and Lance were agreed 'that it was difficult in a case such as the present to separate possibility and speculation'. The AAT affirmed the decision under review, saying:

> 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.

The applicant challenged the AAT's decision on the following grounds:

- The AAT erred in that it should not have asked whether each element of the hypothesis was supported by evidence tending to establish it, but rather should have considered whether there was material 'pointing to raised facts supporting the hypothesis as a whole'.
- The AAT's finding that the hypothesis 'cannot be considered reasonable' shows that the Tribunal considered that as a matter of law it could not find that a reasonable hypothesis existed, when it was a matter of discretion.
- The AAT made an assessment of the medical experts' opinions, when it should have postponed any assessment until it was considering, in accordance with s 120(1), whether the hypothesis was disproved beyond a reasonable doubt.
- The AAT's characterisation that the views of the medical experts were 'mere speculation' was not equivalent to a hypothesis which was 'too remote or too tenuous', being the test referred to in *Byrnes v Repatriation Commission* (1993) 177 CLR 564.

The Court said:

> [23] … Determining whether an hypothesis is reasonable requires a consideration of the whole of the material before the Tribunal, 'not whether an hypothesis of connection would be reasonable if some facts are ignored': see *Owens* at 904. In *Bushell* the High Court observed that an hypothesis may be reasonable although it is unproved and said at 414:
>
> > 'The material will raise a reasonable hypothesis within the meaning of s 120(3) if the material points to some fact or facts ("the

raised facts") which support the hypothesis and if the hypothesis can be regarded as reasonable if the raised facts are true.'

[24] However, the High Court, adopting the observations of the Full Federal Court in *East v Repatriation Commission* (1987) 16 FCR 517, also observed at 414:

'... a hypothesis cannot be reasonable if it is "contrary to proved scientific facts or to the known phenomena of nature". Nor can it be reasonable if it is "obviously fanciful, impossible, incredible or not tenable or too remote or too tenuous".' [footnotes omitted]

[25] In *Bull* Emmett and Allsop JJ observed at [18]:

'It is important to understand the following about East. The court said that an hypothesis is not reasonable if it is obviously fanciful or impossible or incredible or not tenable or too remote or too tenuous. However, the Full Court did ***not*** say that if an hypothesis was not obviously fanciful or not impossible, or not incredible or tenable or not too remote or not too tenuous, it was therefore necessarily reasonable. The material must point to the connecting hypothesis ...' [emphasis in original]

[26] In *Repatriation Commission v Bey* (1997) 79 FCR 364 the Full Federal Court observed as follows (at 372-3):

'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. That understanding of the expression gives force to the word "reasonable", is strongly supported by the history of the relevant provisions, and accords with the intention appearing in the Minister's second reading speech and with authority.'

[27] The Court in *Repatriation Commission v Webb* (1998) 51 ALD 575 considered the approach to be taken in determining whether a hypothesis was reasonable. In that decision, the Court said at 582:

'The proper approach is to ask, in relation to each sequential part of the hypothesis, whether the facts point to that ***part*** of the hypothesis being reasonable. Once it is established that a relevant part of the overall hypothesis is reasonable, then any doubts as to the reasonableness of that part of a hypothesis must, for the purposes of s 120(3), be put aside, and the next part of the hypothesis considered.' [original emphasis]

The Court then considered the applicant's grounds of appeal and said:

[30] As stated in *Bey*, however, a mere possibility is not enough. There must be evidence which points to the suggested hypothesis. The crucial link in this case was whether Mr Streatfield had ***in fact*** been suffering a headache at the time of his accident. This did not have to be proved beyond a reasonable doubt, or on the balance of probabilities, but there had to be material which pointed to it. There was no such material. Accordingly the Tribunal considered, and I agree, that any suggestion that Mr Streatfield did

have a headache on the day in question was mere speculation.

…

[32] The Tribunal was required to assess the material before it in determining whether that element of the hypothesis was reasonable. It did not reject the possibility suggested by Professor Corbett as entirely impossible. It simply determined that, having regard to the material as a whole, it was speculation that headaches caused the accident. It was entitled to come to the finding that it did because, as admitted by Professor Corbett, there was no evidence to suggest that Mr Streatfield had in fact been suffering from a headache on the day of his death. …

[33] The applicant suggests that a hypothesis based upon speculation is not necessarily an unreasonable hypothesis, and relies upon *Lowerson v Repatriation Commission* (1994) 50 FCR 252 at 266. However, I am satisfied in this case that the Tribunal used the term 'speculation' to indicate that it considered the hypothesis to be too remote or too tenuous, in the sense considered in *Bushell*, to be considered a reasonable hypothesis for the purposes of s 120(3). The facts relied upon, even if true, were not sufficient to found a reasonable hypothesis.

[34] The applicant's final submission is that the use of the word 'cannot' in the statement by the Tribunal that 'the hypothesis cannot be considered reasonable' suggests that the Tribunal believed that, based upon its finding that some of the evidence was speculative, it was bound by law to find the hypothesis unreasonable. …

[35] I do not accept that the Tribunal in this case considered itself 'bound' to determine that the hypothesis was unreasonable because it had concluded that the material relating to whether Mr Streatfield had a headache was speculative. Rather, the Tribunal was expressing the fact that, in view of its assessment of the materials, it did not consider the hypothesis to be reasonable. …

The Court dismissed the appeal and ordered Mrs Streatfield to pay the Commission's costs.

Editor: This case is similar to *McLean v Repatriation Commission* [2001] FCA 1505, (2001) 17 *VeRBosity* 110 (the 'falling rock' case) and reinforces the principles expressed there concerning absence of evidence on fundamental aspects of the hypothesis. For a hypothesis to be reasonable, essential elements of the hypothesis must be pointed to by objective evidence, not left open to speculation.

Federal Magistrates Court of Australia

Finger v Repatriation Commission

Riethmuller FM
[2006] FMCA 1075
31 July 2006

***Reasonable hypotheses – evidence required to raise a hypothesis at step 1 of* Deledio**

Mr Finger's made a claim for post traumatic stress disorder, which was diagnosed as depressive disorder and rejected by the Repatriation Commission. The VRB and AAT affirmed that decision.

Mr Finger had served with the 4th Battalion RAR for 7 months in 1968 in Vietnam, but had no recollection of any particular events in that period. He had only vague memories of his service in Vietnam. Nevertheless, it was submitted that given the nature of service in Vietnam, he must have been exposed to severely stressful events because he had a psychiatric disorder.

The AAT accepted the diagnosis of chronic depressive disorder but acknowledged that according to one psychiatrist, some of the symptomatology was consistent with post traumatic stress disorder. The AAT considered the claim under both diagnoses and the factors in both SoPs concerning stressors. The AAT said:

> [104] … The only information that Mr Finger was able to impart came primarily from discussion with other veterans or was a vague recollection of non-stressful events. …
>
> [106] Despite Mr Finger's efforts to refresh his memory by speaking to other Vietnam veterans who may have served at the same time as himself in the Signal Platoon, none of the veterans or the relevant officers are able to remember Mr Finger or are aware of any traumatic events he may have experienced.

The AAT found that Mr Finger did not have any of the symptoms in criterion B of the DSM-IV criteria for post traumatic stress disorder, and found that it was satisfied beyond reasonable doubt that his chronic depressive disorder was not war-caused.

It was argued on appeal before the Federal Magistrates Court that the AAT had failed to apply s 119 of the VEA. It was argued that the AAT should have accepted an argument based on the effect of s 119 that:

- The applicant had to have suffered an event that could be the cause of his condition;
- The difficulties in providing evidence of an event where the applicant could not recall an event and there was no record of an event should be taken into account under s 119;

- An event should be assumed because events of the type needed to satisfy the stressor factor in the SoPs did occur to other soldiers in Vietnam.

The Court rejected that proposition, saying:

> [40] Sections such as 119 (and principles such as that described in *Jones v Dunkel* [1959] HCA 8; (1959) 101 CLR 298) can not lead to a finding that an event occurred where there is no direct or circumstantial evidence to support the proposition. The principles mean that a decision maker should be comfortable making a finding on far less evidence in the circumstances referred to in the section. In this case the evidence did not go beyond speculation that the applicant experienced a relevant event.

The Court noted that the AAT had considered the SoP for post traumatic stress disorder and said:

> [13] … Without any memory of an event (specific or vague) the applicant could not satisfy this part of the SoP [criterion B of the definition of PTSD] as he is not able to re-experience the event. To the extent that the tribunal member considered the applicant's case for PTSD beyond this point was overly generous to the applicant.

In relation to chronic depressive disorder, the Court noted that the AAT had not properly identified the hypothesis that was said to be raised at step 1 of the *Deledio* process. It said:

> [17] … The effect of the findings is that the applicant could only fall within the SoPs if assumptions were made. Whilst the tribunal member did not make specific findings as to the terms of the hypothesis that was being considered this was a product of the failure of the applicant's solicitor to provide a specific hypothesis.
>
> …
>
> [21] In the absence of any evidence identifying a 'severe psychosocial stressor' it is difficult to understand how this case could fall within clause 5(b) of the SoP.
>
> …
>
> [23] … Put simply, the applicant never advanced an hypothesis that had any evidentiary foundation, capable of falling within either SoP.
>
> [24] Not surprisingly, the tribunal found itself satisfied beyond reasonable doubt that there was no severe psychological stressor, given that there was no evidence of an occurrence that had any impact on the applicant, even from the applicant himself. It must be noted that this was not a case where there was simply no evidence, but a case where there was evidence of enquiry by the applicant of other soldiers, and of a senior officer (Colonel Church), and the Commanding Signals Officer of the 4th Battalion during the relevant period (Mr Innes). The only way to prove a negative proposition is to provide evidence that enquiries of the potential sources of evidence of the event occurring: this the respondent did at the hearing.

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

Editor: While the AAT's decision was upheld, the Court expressed some criticism of the AAT's decision-making processes. The AAT should

have identified and settled on the relevant kind of injury or disease before considering any hypotheses or SoPs. If it had done so, there would have been no need to have considered the PTSD SoP.

The AAT did not identify a hypothesis raised by the material before it, yet still proceeded to consider the SoPs. As was noted by the Court, no hypothesis could have been raised by the evidence before the AAT and so it should have finished at step 1 of the *Deledio* process, rejecting the claim on the ground that no hypothesis was raised by the evidence.

The important point to be taken from this case was made at paragraph [42] where the Court said that 'if the four steps in *Deledio* were closely followed it would be difficult for a tribunal to fall into error.' In this case it would also have made the decision-making process simpler.

Thomas v Repatriation Commission

Jarrett FM
[2006] FMCA 618
28 April 2006

Generalised anxiety disorder – post traumatic stress disorder – alcohol dependence

Mr. Thomas appealed a decision of the AAT that had affirmed the rejection of his claim in respect of generalised anxiety disorder, post traumatic stress disorder and alcohol dependence.

Mr Thomas claimed that while at Ubon, Thailand in 1966, he experienced a number of stressful events that led to the development of the claimed conditions.

The alleged stressful events were:

- being soaked in aircraft fuel leading to painful skin effects on his stomach, groin, testicles and penis;
- having sleeping quarters close to an aircraft runway;
- having sleeping quarters close to a fuel dump;
- a taxiing RAAF Sabre jet accidentally fired across his tanker truck;
- an armed person jumped onto his truck and Mr Thomas had to push him off;
- concern that insurgents might fire mortars at him;
- seeing a Thai guard shot through the head for sleeping at his post;
- sustaining a bayonet wound and being assaulted by Thai police;
- the incineration of an American serviceman in a fire.

The AAT found that the evidence, if true, pointed to hypotheses that the stressors contributed to the cause of Mr Thomas' claimed conditions.

The AAT then considered whether the hypotheses were upheld by the relevant SoPs.

In relation to generalised anxiety disorder, the AAT found that the evidence did not point to all the diagnostic criteria being met within two years of the alleged stressors, and so the hypothesis in that regard was not reasonable.

In relation to the post traumatic stress disorder and alcohol dependence, the AAT found that the hypotheses were reasonable (except for those relating to the location of his sleeping quarters – as that could not amount to a severe psychosocial stressor).

The AAT then turned to step 4 of Deledio, which involves whether any of the facts necessary for the hypotheses are disproved beyond a reasonable doubt.

The AAT found that none of the events relied upon by Mr Thomas actually happened. Specifically, the AAT found that:

- the applicant did not witness a Thai guard being shot as he alleged;
- his claim about being present when an American serviceman was incinerated in a brothel fire was false;
- he and the vehicle he was driving were not fired upon by an RAAF Sabre aircraft as he alleged;
- an armed man did not jump onto his truck as he alleged;
- his complaints of penile problems were not attributable to being doused with jet fuel, but more likely were due to exposure to sexually transmissible disease.

As a consequence of these findings, the AAT found beyond reasonable doubt that none of the claimed conditions were related to Mr Thomas' operational service in Ubon.

The grounds of appeal were that:

- the AAT had misapplied *White* and *Stoddart* by holding that there was a need for a personal attack or threat upon the applicant to have suffered a relevant stressor; and
- the AAT failed to apply the steps in Deledio when it found that the evidence was insufficient at step 3 for there to be a reasonable hypothesis in relation to the generalised anxiety disorder.

The Court held that the first ground was not a question of law. It was merely an assertion of an error in failing to properly apply the law in not finding that all the alleged stressors cold have been severe psychosocial stressors. The Court said:

> [24] … The Tribunal's finding that those matters did not amount to a severe psychosocial stressor was plainly open to it on the evidence. No question of law is involved. The Tribunal has simply made an assessment of the evidence before it and determined that the applicant's experience of residing close to fuel depots did not amount to a severe psychosocial stressor for the purposes of the relevant SoP.

The Court also held that the second ground was not a question of law. It said:

> [25] … The Tribunal did not ignore the medical evidence of Dr Carter (who in 2005 diagnosed the applicant as having a generalised anxiety disorder some 38 years earlier). The Tribunal chose not to accept it for the reasons it expressed, namely that her evidence did not 'provide any basis of Mr Thomas

suffering from all of the features of a generalised anxiety disorder within the meaning of the definition of "generalised anxiety disorder"...'. Even at the third stage of the *Deledio* process, that course was open to the Tribunal because its task was to determine if, on the whole of the evidence before it, the facts were consistent with the SoP and the applicant's hypothesis therefore reasonable.

…

[27] The applicant argues that the Tribunal misapplied s.119(h) of the VE Act 'in finding that there were no contemporaneous medical records'. The allegation is made in the context of the Tribunal's finding that the evidence did not provide any basis to find that the applicant was suffering from the features of a generalised anxiety disorder during a two year period following the onset of his acute penile problems. The Tribunal made no such finding. In fact, the Tribunal had regard, in a careful and detailed way, to the applicant's medical records while he was at Ubon. If nothing else, the questions asked of the medical witnesses during the hearing make that clear. What the Tribunal in fact found was that: 'There are no contemporaneous medical records that support the view that Mr Thomas was suffering from all the cumulative features in the definition'. That finding was open on the evidence.

[28] The second purported question of law is not a question of law, but rather another assertion that the Tribunal erred in its application of the *Deledio* steps. In my view it did not do so. It followed the steps and found that in each of the claimed conditions the facts, or some of them, were consistent with the relevant SoPs. The applicant failed because ultimately the Tribunal did not believe the applicant's evidence in crucial respects.

[29] The third asserted question of law asserts that the Tribunal applied 'the incorrect principles in the analysis of the onus of proof.'. Again, no question of law is posed as the question is framed. The grounds relied upon assert that the Tribunal misapplied the 'criteria for the onus of proof under the Act, confusing the requirement as set out in s 120 with the concept referred to in s 120(6).'

[30] The fourth step of the *Deledio* steps is the appropriate time for the Tribunal to make findings of fact in relation to the claims before it. Far from the Tribunal placing any onus upon the applicant to prove its case, for the reasons expressed by the Tribunal, it could not find that many of his claims were true. That was not a finding made lightly by the Tribunal. The Tribunal carefully had regard to all of the evidence, including the evidence of Writeway Research and the applicant's own previous (inconsistent) evidence on various occasions. The Tribunal was not bound to accept the applicant's evidence in all, or in any respects.

[31] In my view no error of law, let alone a question of law, has been demonstrated.

The Court dismissed the appeal.

Statements of Principles issued by the Repatriation Medical Authority

July – September 2006

Number of Instrument	Description of Instrument
35 of 2006	Revocation of Statement of Principles (Instrument No 169 of 1996) and determination of Statement of Principles concerning **acute myeloid leukaemia** and death from acute myeloid leukaemia.
36 of 2006	Revocation of Statement of Principles (Instrument No 170 of 1996) and determination of Statement of Principles concerning **acute myeloid leukaemia** and death from acute myeloid leukaemia.
37 of 2006	Revocation of Statement of Principles (Instrument No 15 of 2000) and determination of Statement of Principles concerning **myelodysplastic disorder** and death from myelodysplastic disorder.
38 of 2006	Revocation of Statement of Principles (Instrument No 16 of 2000) and determination of Statement of Principles concerning **myelodysplastic disorder** and death from myelodysplastic disorder.
39 of 2006	Revocation of Statement of Principles (Instrument No 83 of 1997) and determination of Statement of Principles concerning **rotator cuff syndrome** and death from rotator cuff syndrome.
40 of 2006	Revocation of Statement of Principles (Instrument No 84 of 1997) and determination of Statement of Principles concerning **rotator cuff syndrome** and death from rotator cuff syndrome.
41 of 2006	Revocation of Statement of Principles (Instrument No 37 of 1994 as amended by No 195 of 1995) and determination of Statement of Principles concerning **external burn** and death from external burn.
42 of 2006	Revocation of Statement of Principles (Instrument No 38 of 1994 as amended by No 196 of 1995) and determination of Statement of Principles concerning **external burn** and death from external burn.
43 of 2006	Revocation of Statement of Principles (Instrument No 147 of 1995) and determination of Statement of Principles concerning **decompression sickness** and death from decompression sickness.
44 of 2006	Revocation of Statement of Principles (Instrument No 148 of 1995) and determination of Statement of Principles concerning **decompression sickness** and death from decompression sickness.
45 of 2006	Determination of Statement of Principles concerning **pulmonary barotrauma** and death from pulmonary barotrauma.
46 of 2006	Determination of Statement of Principles concerning **pulmonary barotrauma** and death from pulmonary barotrauma.

47 of 2006	Determination of Statement of Principles concerning **dysbaric osteonecrosis** and death from dysbaric osteonecrosis.
48 of 2006	Determination of Statement of Principles concerning **dysbaric osteonecrosis** and death from dysbaric osteonecrosis.
49 of 2006	Determination of Statement of Principles concerning **shin splints** and death from shin splints.
50 of 2006	Determination of Statement of Principles concerning **shin splints** and death from shin splints.

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 September 2006

Description of disease or injury	*SoPs under consideration*	Gazetted
Achilles tendonitis or bursitis	*Instrument Nos. 53/96 & 54/96*	19-11-03
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 neoplasm of the eye	*Instrument Nos. 1825/95 & 183/95*	28-06-06
Benign prostatic hypertrophy	*Instrument Nos. 133/95 & 134/95*	28-06-06
Binge eating disorder	—	15-06-05
Bipolar disorder	*Instrument Nos 128/96 & 129/96*	24-03-04
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

Description of disease or injury	*SoPs under consideration*	Gazetted
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
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
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

Description of disease or injury	*SoPs under consideration*	Gazetted
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
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
Sarcoidosis	*Instrument Nos. 288/95 & 289/95*	28-06-06
Secondary parkinsonism	*Instrument Nos 38/02 & 39/02*	2-03-05
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 – July to September 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*

Application for review

dismissal of Veterans' Review Board application
- failure to respond to notice
  - representative claimed to have posted response in time
    Dor, C
    [2006] AATA 767 8 September 2006

Carcinoma

prostate
- high fat diet
  - influence of smoking on metabolic rate
    Harmer, K (Army) (death)
    [2006] AATA 663 28 July 2006

Circulatory disorder

deep vein thrombosis
- whether contributed to death
  Harrison, P (Army) (death)
  [2006] AATA 740 1 August 2006

hypertension
- alcohol
  Cotton, G (RAAF)
  [2006] AATA 648 24 July 2006

ischaemic heart disease
- diagnosis
  Hoey, N (Navy)
  [2006] AATA 775 11 September 2006
- hypertension
  Cotton, G (RAAF)
  [2006] AATA 648 24 July 2006

Date of effect

unaware of right to make claim
- cannot be backdated earlier than 3 months before claim made
  Johnston, J
  [2006] AATA 627 17 July 2006

Death

death certificate
- accuracy doubted
  Harrison, P (Army)
  [2006] AATA 740 1 August 2006

hastening of death
- Alzheimer's disease
  Poole, N (RAAF)
  [2006] AATA 671 1 August 2006
- chronic obstructive airways disease
  Poole, N (RAAF)
  [2006] AATA 671 1 August 2006

kind of death
- meaning
  Brown (Branson J)
  [2006] FCA 914 19 July 2006
- real or operative cause, not terminal event
  Brown (Branson J)
  [2006] FCA 914 19 July 2006

Dependant

reinstated widow's pensioner
- not receiving pension before 28 May1984
  Nunn, E
  [2006] AATA 651 25 July 2006
- remarried before 28 May1984
  Nunn, E
  [2006] AATA 651 25 July 2006

remarried after veteran's death
- ceased to be a dependant
  Nunn, E
  [2006] AATA 651 25 July 2006

Disability pension – assessment of incapacity

extreme disablement adjustment
- lifestyle rating
  Ross Smith, E
  [2006] AATA 739 30 August 2006

Eligible service

whether a veteran or member of the Forces
- entertainer in Vietnam
  - Ministerial determination
    Iversen (Edmonds J)
    [2006] FCA 942 28 July 2006
  - whether a representative of AFOF
    Iversen (Edmonds J)
    [2006] FCA 942 28 July 2006

Endocrine and metabolic disorder

diabetes mellitus
- smoking cessation
  Johnson, R (Army)
  [2006] AATA 768 8 September 2006

Entitlement and liability

arose out of or was attributable to
- defence service
  Roncevich, J J (Army)
  [2006] AATA 660 26 July 2006

events occurring when off duty
- mess function
  Roncevich, J J (Army)
  [2006] AATA 660 26 July 2006

failure to obtain a benefit in connection with employment
- overtime
  Williams and APC (SRCA)
  [2006] AATA 695 11 August 2006

Evidence and proof

application of *Deledio* steps
- assessing reasonableness of hypothesis
  Streatfield (Cowdroy J)
  [2006] FCA 984 2 August 2006
- assessment of credibility at step 4
  Thomas (Jarrett FM)
  [2006] FMCA 618 28 April 2006
- assessment of the material
  Streatfield (Cowdroy J)
  [2006] FCA 984 2 August 2006
- hypothesis must be raised by factual material
  Streatfield (Cowdroy J)
  [2006] FCA 984 2 August 2006
- lack of evidence to raise a hypothesis at step 1
  Finger (Riethmuller FM)
  [2006] FMCA 1075 31 July 2006

credibility
- assessed at *Deledio* step 4
  Thomas (Jarrett FM)
  [2006] FMCA 618 28 April 2006
- deceit and manipulation a feature of diagnosed psychiatric condition
  Fenner, J K (Navy)
  [2006] AATA 766 8 September 2006
- failure to tell story on previous occasions
  Fenner, J K (Navy)
  [2006] AATA 766 8 September 2006
- inconsistencies in evidence
  Fenner, J K (Navy)
  [2006] AATA 766 8 September 2006
- treatingdoctor
  - become an advocate
    Marsh, J D (Navy)
    [2006] AATA 789 15 September 2006

expert
- evidence of medical practitioner outside field of expertise of no assistance
  Morrison, V (death)
  [2006] AATA 675 2 August 2006
- treatingdoctor
  - become an advocate
    Marsh, J D (Navy)
    [2006] AATA 789 15 September 2006

insufficient evidence
- s 119 VEA considered
  Finger (Riethmuller FM)
  [2006] FMCA 1075 31 July 2006

postal rule
- whether document provided to Principal Member
  Dor, C
  [2006] AATA 767 8 September 2006

Infection

multi-resistant *staphylococcus aureus*
- lung damage due to smoking
  Morrison, V (death)
  [2006] AATA 675 2 August 2006

Jurisdiction and powers

matter under review
- issues to be decided in claim for war widow's pension
  Nunn, E
  [2006] AATA 651 25 July 2006

Musculoskeletal disorder

internal derangement of knee
- diagnosis
Roncevich, J J (Army)
[2006] AATA 660 26 July 2006
- fall
Roncevich, J J (Army)
[2006] AATA 660 26 July 2006

osteoarthrosis of knee
- diagnosis
Roncevich, J J (Army)
[2006] AATA 660 26 July 2006

Neurological disorder

Alzheimer's disease
- vitamin B12 deficiency
Harrison, P (Army) (death)
[2006] AATA 740 1 August 2006

epilepsy
- alcohol abuse
Bachelor, D W (Army)
[2006] AATA 615 11 July 2006

Permanent impairment

permanency
- different range of movement measurements on different occasions
Carter, S J (SRCA)
[2006] AATA 721 21 August 2006

Psychiatric disorder

alcohol abuse or dependence
- aggravation
  - no evidence of clinical worsening
Aitken, R (Navy)
[2006] AATA 688 9 August 2006
- clinical onset
Aitken, R (Navy)
[2006] AATA 688 9 August 2006
- experiencing a severe stressor
  - accidental weapon discharge
Warren, M A (Army)
[2006] AATA 605 7 July 2006
  - confrontation with guard
Warren, M A (Army)
[2006] AATA 605 7 July 2006
  - fear of torpedo attack
Fenner, J K (Navy)
[2006] AATA 766 8 September 2006
  - Ferriday shooting
Bachelor, D W (Army)
[2006] AATA 615 11 July 2006
  - heard shots and told soldiers were killed
Bachelor, D W (Army)
[2006] AATA 615 11 July 2006
  - scare charge
Fenner, J K (Navy)
[2006] AATA 766 8 September 2006
  - threatened by armed children
Dahl-Helm, C (Army)
[2006] AATA 817 25 September 2006
  - threatened by villagers while driving Land Rover
Brooking, W (Army)
[2006] AATA 826 28 September 2006
  - witnessed mutilated children
Dahl-Helm, C (Army)
[2006] AATA 817 25 September 2006

anxiety disorder
- aggravation
  - temporary
Johnson, R (Army)
[2006] AATA 768 8 September 2006
- clinical onset
Johnson, R (Army)
[2006] AATA 768 8 September 2006
- before experiencing stressor
McCutcheon, Q A (RAAF)
[2006] AATA 744 31 August 2006
- diagnosis
Roberts, A (Navy)
[2006] AATA 631 17 July 2006
- due to general medical condition
  - atrial fibrillation
Roberts, A (Navy)
[2006] AATA 631 17 July 2006
  - respiratory disorder
Roberts, A (Navy)
[2006] AATA 631 17 July 2006
- experiencing a severe stressor
  - blood in helicopter
McCutcheon, Q A (RAAF)
[2006] AATA 744 31 August 2006
  - helicopter manoeuvre – sudden rise and turn
McCutcheon, Q A (RAAF)
[2006] AATA 744 31 August 2006

- junk blown up
Aitken, R (Navy)
[2006] AATA 688 9 August 2006
- near collision of naval vessels
Aitken, R (Navy)
[2006] AATA 688 9 August 2006
- shelling of village
Aitken, R (Navy)
[2006] AATA 688 9 August 2006

depressive disorder
- experiencing a severe stressor
- threatened by armed children
Dahl-Helm, C (Army)
[2006] AATA 817 25 September 2006
- witnessed mutilated children
Dahl-Helm, C (Army)
[2006] AATA 817 25 September 2006

post traumatic stress disorder
- diagnosis
Fenner, J K (Navy)
[2006] AATA 766 8 September 2006
Marsh, J D (Navy)
[2006] AATA 789 15 September 2006
Collins, E (Merchant Navy)
[2006] AATA 833 29 September 2006
- experiencing a severe stressor
- accidental weapon discharge
Warren, M A (Army)
[2006] AATA 605 7 July 2006
- confrontation with guard
Warren, M A (Army)
[2006] AATA 605 7 July 2006
- threatened by villagers while driving Land Rover
Brooking, W (Army)
[2006] AATA 826 28 September 2006

Rehabilitation and treatment

aids and appliances (s 56, MRCA)
- must be specialised and of a rehabilitative character
Hart, N (SRCA)
[2006] AATA 628 17 July 2006

rehabilitation
- whether program reasonable
- moved to new location but program only offered in old location
Galbraith, A (SRCA)
[2006] AATA 762 7 September 2006

travelling expenses (s 290, MRCA)
- whether journey necessary to obtain treatment
- similar treatment available at closer locality
Mecke, R (SRCA)
[2006] AATA 593 4 July 2006

Remunerative work & special rate of pension

date of effect
- not earlier than 3 months before claim made
Johnston, J
[2006] AATA 627 17 July 2006
- unaware of right to make claim
Johnston, J
[2006] AATA 627 17 July 2006

kind of work the person was undertaking
- manufacturing
- plant operator
Strike, C A
[2006] AATA 606 7 July 2006
- transport
- taxi driver
Deloryn, G
[2006] AATA 622 14 July 2006

whether prevented by war-caused disabilities alone
- age
Schellhorn, J
[2006] AATA 697 11 August 2006
- effects of non-accepted disabilities
Strike, C A
[2006] AATA 606 7 July 2006
Deloryn, G
[2006] AATA 622 14 July 2006
- personality traits
- due to psychiatric disorder
Edmonds, D
[2006] AATA 672 1 August 2006
- redundancy
Strike, C A
[2006] AATA 606 7 July 2006
Schellhorn, J
[2006] AATA 697 11 August 2006
- retirement
Schellhorn, J
[2006] AATA 697 11 August 2006
- time out of the workforce
Schellhorn, J
[2006] AATA 697 11 August 2006

Respiratory disorder

chronic bronchitis
- clinical onset
  Linton, G A (Navy)
  [2006] AATA 609 10 July 2006
- fumes from funnel
  Linton, G A (Navy)
  [2006] AATA 609 10 July 2006
- smoking
  Linton, G A (Navy)
  [2006] AATA 609 10 July 2006

chronic obstructive airways disease
- smoking
  Poole, N (RAAF) (death)
  [2006] AATA 671 1 August 2006

Service pension

assets test
- disposal of assets
  - winding up of private company
    Kimpton (French J)
    [2006] AATA 1120 22 August 2006
- private company
  - attribution of assets
    Kimpton (French J)
    [2006] AATA 1120 22 August 2006
  - excluded assets
    Kimpton (French J)
    [2006] AATA 1120 22 August 2006

Skin disorder

discoid eczema
- defoliant chemicals
  Kuhl, D J (Army)
  [2006] AATA 629 17 July 2006
- emotional stress
  Kuhl, D J (Army)
  [2006] AATA 629 17 July 2006

Words and phrases

provide
- whether posting is sufficient
  Dor, C
  [2006] AATA 767 8 September 2006