



WORKERS COMPENSATION COMMISSION

Annual Review

2011

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PRESIDENT'S FOREWORD

In the Foreword to last year's Annual Review, I foreshadowed that, during the course of 2011, the Commission would engage in a formal evaluation of the effectiveness of the recent reforms, including in particular the internal reorganisation and the transition from part-time to full-time Arbitrators. I am pleased to report the outcome of the evaluation process in this year's review.

During the year, the Commission engaged independent consultants, Newfocus, to research satisfaction levels among the Commission's users and stakeholders. The key findings of the research indicated that satisfaction levels among workers and legal representatives had improved significantly since the last research was undertaken three years ago. Satisfaction levels among employers and insurers remained relatively stable.

Mid-year marked the first anniversary of the transition to full-time Arbitrators. I am pleased to report that that initiative, in conjunction with a number of others, has had a very positive effect on the quality and durability of arbitral decisions in the Commission.

Both the number of appeals and determinations revoked have dropped dramatically in comparison with previous years (52 per cent and 46 per cent respectively).

PricewaterhouseCoopers were successful in a competitive tender to undertake a post-implementation evaluation of the effectiveness of the organisational change program. After reviewing the objective data and consulting widely with members and staff of the Commission and relevant stakeholders, a formal evaluation report was submitted at the end of August.

PwC's findings may be summarised as follows:

- decisions have become more durable and the resolution of matters more effective;
- consistency of outcomes between Arbitrators is relatively high, implying that individual Arbitrator approaches to the Dispute Resolution Model (DRM) are fairly consistent;
- generally, external stakeholders are happier with the service at the Commission;
- the durability of the AMS assessments has improved;
- average time to resolve matters overall has improved. There has been a small sacrifice of timeliness between the three and six month bands;
- staff have clarity around the alignment of core functions and the business units to which they now belong. There are several key themes which emerged during the review which may lead to further change.

These outcomes could not have been achieved without the tireless commitment of members and staff of the Commission at all levels throughout the year.

In October, the Government announced its intention to ask the New South Wales Parliament's Standing Committee on Law and Justice to conduct an inquiry into opportunities to consolidate tribunals in New South Wales. At the request of the Committee, the Commission provided a submission, and the Registrar and I gave evidence before the Committee in December. The Commission's principal submission is that it should remain an independent statutory tribunal and should be permitted to continue to function in its present form.

The Commission's submission can be viewed on the Parliamentary website. The Standing Committee is due to report to the Parliament in March 2012.

As in previous years, this Annual Review provides an overview of the role and functions of the Commission during the year. It provides an analysis of the Commission's workload, its performance against key performance indicators and future trends in filings.

In terms of challenges for 2012, I can report that the redevelopment of the Commission's website is well underway. I anticipate that the new website will be operative by April 2012.

Work is also advanced on the preparation of a practice manual for the Commission's Approved Medical Specialists. It is intended that the manual will provide guidance on a range of issues including, among many other things, the dispute resolution framework in which the Approved Medical Specialists operate, guidance on issues such as appointment and code of conduct of AMSs, the conduct of medical examinations, and the preparation of Medical Assessment Certificates. I anticipate that the manual will be provided to Approved Medical Specialists in mid-2012.

Finally, I take this opportunity to express my thanks to the staff of the Commission, the Deputy Presidents, the Deputy Registrars, Arbitrators, Senior Arbitrators and Approved Medical Specialists for their contributions throughout the year. I particularly express my thanks to the Registrar, Sian Leathem, for her continued professionalism and commitment.

His Hon Judge Keating
President



REGISTRAR'S REPORT

2011 was a busy and productive year for the Commission. In addition to receiving more than 12,000 applications, our members and staff were involved in a range of significant projects and activities, including: delivering the WCC Roadshows; commissioning a major client survey; developing and implementing a new performance management system for staff (the Review, Reward and Development System); designing and running educational seminars for insurers; and facilitating the conduct of a post-implementation evaluation of organisational changes. Further information about each of these initiatives is contained in the body of the Annual Review.

Significant efforts were also directed towards improving our internal case management and reporting systems, including the introduction of more rigorous monitoring, exception reporting and auditing systems, and improving the integration of our procedures with the alert functionality of our electronic database. While these initiatives have all taken place 'behind the scenes', they are firmly directed at improving the quality of our services and enhancing the experience of our clients.

Detailed information concerning the Commission's workload appears in Section 3 of this report. In terms of broad trends, there was an overall increase in our workload, with Applications to Resolve a Dispute tracking up by approximately four per cent (representing an additional 304 applications). Mediation Applications continued to rise steadily, with over 1,200 being lodged during the reporting year. This represents an increase of over 40 per cent compared to 2010.

Notwithstanding the increase in applications, the Commission continued to finalise matters in a timely manner, with approximately 40 per cent of Applications to Resolve a Dispute being finalised within three months and over 80 per cent being finalised within six months. There were no matters that remained open for more than 12 months, unless they involved a medical or arbitral appeal.

The Commission's relationship with the Compensation Authorities Staffing Division (CASD) was consolidated and refined during 2011 with the signing of a new Shared Services Agreement.

Through this arrangement, the Commission will continue to receive a suite of corporate services, including: information technology, finance, payroll, site services and human resource support.

As always, the Commission's achievements are the result of the combined expertise, dedication and commitment of its members and staff. I would like to take the opportunity to extend my thanks to the President, Deputy Presidents, Deputy Registrars, members, staff and all of our service partners for their contribution and support throughout 2011.

Sian Leathem
Registrar

DEVELOPMENTS IN 2011

Highlights of 2011

Roadshows

In February 2011, the Commission conducted a series of free information sessions for legal practitioners, insurers and other interested parties. The sessions were attended by over 500 participants in a range of metropolitan and regional locations. Further information is contained in Section 5 of the Annual Review.

2011–2014 Strategic Plan

In June 2011, the Commission developed and finalised a three-year Strategic Plan for 2011–2014. Further information is contained in Section 4 of the Annual Review.

Review, Recognition and Development System

During 2011, the Commission introduced the Review, Recognition and Development (RRD) program for staff. The RRD is a system developed to improve performance by providing a clear basis for developing individual capabilities, reviewing performance, determining training and skills development needs, and recognising achievements. Further information is contained in Section 4 of the Annual Review.

Client Survey

During 2011, the Commission engaged Newfocus consultants to undertake a client survey, gathering the views of workers, employers, insurers and legal practitioners. It is the third time the Commission has conducted client research, with previous surveys conducted in 2004 and 2008. The research aims to:

- Identify the Commission's strengths and opportunities for service improvements;
- Understand user expectations and experiences regarding Commission services;
- Measure satisfaction with these services; and
- Get feedback on information provision, sources of communication and access and equity issues.

The 2011 report includes many findings across a broad range of areas, including a range of improvements such as:

- An increase in the level of understanding of the Commission's role and responsibilities compared to the 2008 survey;
- 80 per cent of legal representatives are satisfied or very satisfied with Commission's services (up from 54 per cent in 2008);
- 71 per cent of workers are satisfied or very satisfied (up from 70 per cent in 2008);
- 43 per cent of insurers are satisfied or very satisfied (up from 39 per cent in 2008); and
- 35 per cent of employers are satisfied or very satisfied (equal to 2008 levels).

The report also identifies a number of opportunities for improvement, such as more effective information provision and communication with insurers and employers, as well as regional access for conduct of medical examinations and conciliations/arbitrations.

The results will be used to inform organisational initiatives and activities over the next three years.

Further information is contained in Section 4 of the Annual Review.

Post-implementation review of organisational changes

During 2011, the Commission retained PricewaterhouseCoopers (PwC) to undertake an evaluation of the effectiveness of the recent reforms affecting the Commission. In particular, PwC examined the changes to arbitral services and the effectiveness of the internal structural changes. The final report was received by the Commission in August 2011.

Pleasingly, PwC's report included a range of positive findings about the success of the organisational changes, including:

- Arbitral decisions have become more durable and the resolution of matters more effective;

"Six months after the introduction of the changes in July 2010, revocation rates dramatically dropped by 70%. In addition, the total number of appeals revoked for 2011 dropped by 52%, whilst the total number of determined disputes only dropped 19% by comparison. The implication of these results is that decisions have become more durable since the portfolio of changes have been implemented. This is also supported by the 8% drop in the annual revocation rates as a percentage of determined disputes from 2010 to 2011.

Consequently (and also as a result of changes in legislation), the total number of appeals dropped by 46% whilst the annual rate of appeals as a percentage of determined disputes has dropped (11%). This has also seen the number of Acting Deputy Presidential positions (as a supplement to Deputy Presidential positions) decrease as appeal workloads have decreased. This indicates that there has been an increase in the effective resolution of matters." PwC Final Report, p 7.

- Consistency of outcomes between Arbitrators is relatively high; "...decision making of individual Arbitrators is generally more consistent in 2011 than 2010.

The Newfocus client survey for 2011 seems to support this view as it indicates that legal representatives felt consistency has improved, although the perceived change was not significant. This is may be due to the fact that the changes have been so recent that stakeholders are yet to experience the effect. This view was supported by Workcover." PwC Final Report, p 8

- External stakeholders are more satisfied with the Commission's services;

"The Newfocus client survey for 2011 indicated that client satisfaction with the Commission and Arbitrators had generally increased since the survey in 2008. This increase was most notable for legal representatives, whose overall satisfaction with Arbitrator teleconferences had gone from 51% to 75%.

In addition, overall satisfaction with Arbitrators at con/arbs had gone from 53% to 82%. It was noted anecdotally that legal representatives are the most common parties attending these hearings and as a result, were best placed to provide feedback in relation to the same.

Insurer satisfaction with the Commission and the Arbitrators has also increased. Both legal representatives and insurers are happier with the Arbitrators' understanding of the law, their neutrality and their understanding of the issues in the dispute. It is also important to note that worker satisfaction with the Commission has remained high, although has not necessarily increased for all aspects." PwC Final Report, p 9

- Durability of medical assessments has improved; "The effectiveness of the change with respect to the AMS was limited to confirming that durability has improved, with revocation rates reduced to 6%." PwC Final Report, p 9
- Average time to resolve matters has improved, with a small sacrifice in timeliness between the three- and six-month bands; and "Overall, the annual average time taken to resolve matters has improved since 2010." PwC Final Report, p 10



→ The internal restructure had been effective in better aligning business units with core functions.

"The restructuring of the business units to align with core functions has universally been considered a success. Generally, staff and Arbitrators feel comfortable with their understanding of their roles and their workload levels. They also enjoyed the opportunity to 'act up' and felt that in most areas there was an improvement in their ability for career progression. They also generally enjoy working with their team members in the individual business units." PwC Final Report, p 11

Further information is contained in Section 4 of the Annual Review.

Priorities for 2012

The Commission's Corporate Plan identifies a number of priorities for 2012, including:

New website and intranet

In late 2011, the Commission engaged Australian SharePoint specialists, OBS, to design and build a new website and intranet. It is anticipated the new site will go live in April 2012.

Launch of AMS Practice Manual

In late 2011, work commenced on the development of a comprehensive Practice Manual for the Commission's Approved Medical Specialists. The Practice Manual will contain a range of information on practice and procedure in the Commission to assist Approved Medical Specialists. It is expected to be launched in mid-2012.

Recruitment/Reappointment of AMSs

The current appointments for Approved Medical Specialists expire in October 2012. The Commission and the WorkCover Authority will commence planning the recruitment and reappointment process in early 2012.

E-Screen enhancements

In October 2010, the Commission launched an online lodgment facility, known as e-Screens. Since that time, a number of potential enhancements have been identified to improve the usability of e-Screens. It is anticipated the enhancements will become available during the first half of 2012.



THE COMMISSION

Who we are

The Workers Compensation Commission (the Commission) is an independent statutory tribunal within the justice system of New South Wales. It was established under the *Workplace Injury Management and Workers Compensation Act 1998* and commenced operation on 1 January 2002.

The Commission is part of a broader statutory scheme for dealing with workers compensation issues and claims. Within that broader scheme, the Commission's role is to resolve disputes between injured workers and employers over workers compensation claims.

The Commission's non-adversarial dispute resolution process is at the vanguard of dispute resolution in Australia. The parties are directly involved in an accessible and accountable process that ensures injured workers obtain a fair and quick resolution to disputes about workers compensation entitlements.

The Honourable Greg Pearce MLC (Minister for Finance and Services, Minister for the Illawarra) is the Minister under whose auspices the Commission falls. However, the Attorney General has responsibility for the administration of those sections of the *Workplace Injury Management and Workers Compensation Act 1998* concerning the appointment of the various types of members of the Commission and the remuneration of Arbitrators.

Legislation

The legislation governing the Commission includes:

- *Workplace Injury Management and Workers Compensation Act 1998*;
- *Workers Compensation Act 1987*;
- *Workers Compensation Regulation 2010*; and
- *Workers Compensation Commission Rules 2011*.

Objectives of the Commission

Section 367 of the *Workplace Injury Management and Workers Compensation Act 1998* charges the Commission with the following objectives:

- To provide a fair and cost-effective system for the resolution of disputes;
- To reduce administrative costs;
- To provide a timely service;
- To create a registry and dispute resolution service that meets expectations in relation to accessibility, approachability and professionalism;
- To provide an independent dispute resolution service that is effective in settling disputes and leads to durable agreements; and
- To establish effective communication and liaison with interested parties.

These objectives are both challenging and significant. Over the last 10 years, the Commission has built a solid foundation of achievement aligned with these objectives.

What we do

Simply put, the Commission resolves disputes between injured workers and their employers.

There are several different paths that applications can travel before they reach resolution: for example, arbitration, medical assessment, mediation, and expedited assessment. The path selected depends on the issues in dispute and the steps involved vary according to the complexity of the matter.

The main areas of dispute between parties include claims relating to:

- Weekly compensation payments;
- Medical expenses compensation;
- Compensation to dependants of deceased workers;
- Injury management;
- Lump sum compensation for permanent impairment/pain and suffering;
- Work injury damages; and/or
- Legal costs.



The Commission has an internal appellate jurisdiction that is a distinguishing feature of its operations. The Presidential Members of the Commission conduct appeals from the decisions of the Arbitrators.

Similarly, Medical Appeal Panels determine appeals against assessments by Approved Medical Specialists.

Further details about the people involved in resolving different types of disputes and the processes that are followed can be found in later sections of this Annual Review.

How we do it

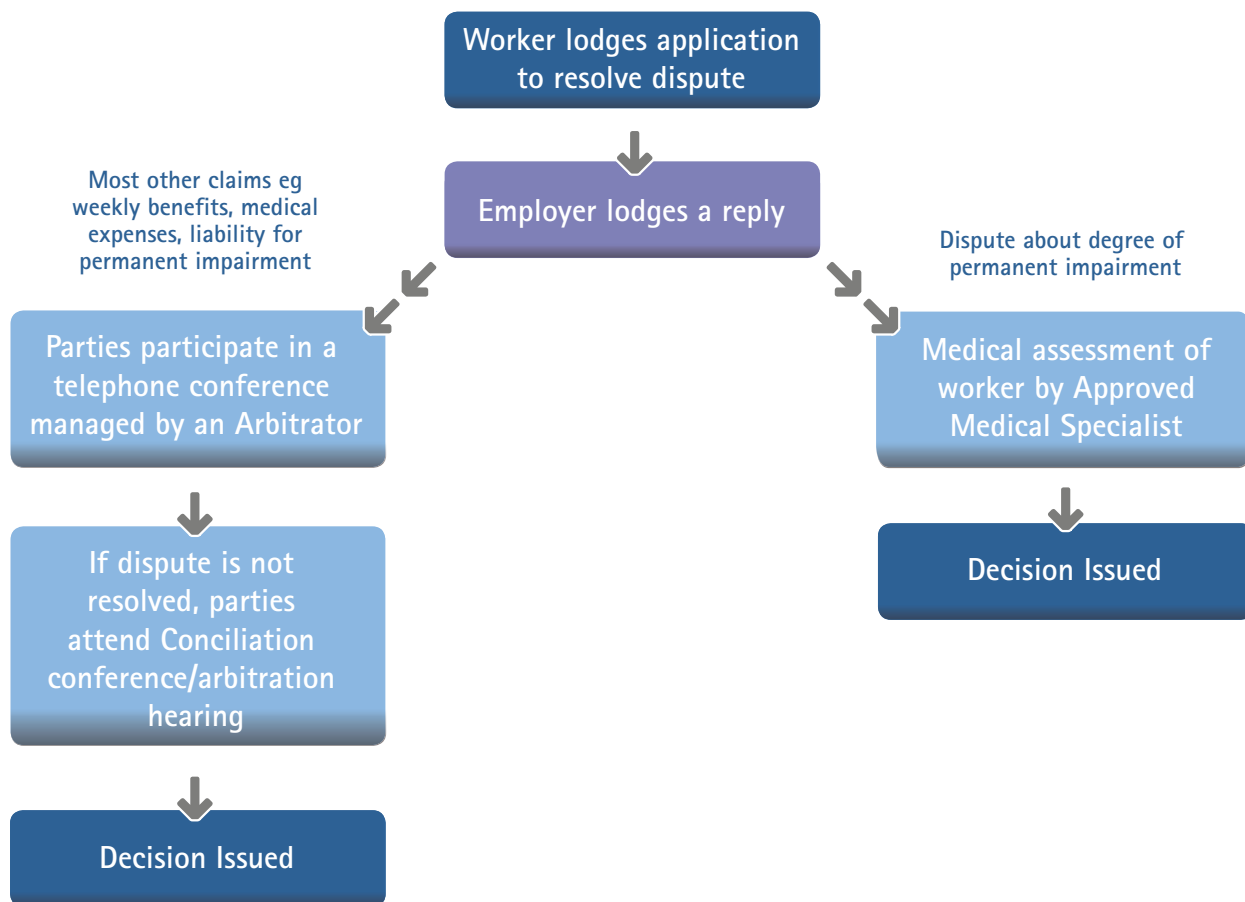
How the process works

The process for resolving a dispute depends on the type of claim that is in dispute.

Where the only issue in dispute is the degree of permanent impairment, the Registrar will refer those claims directly to an Approved Medical Specialist for medical assessment following the period for lodging any reply to the application. The parties will be notified of the details of the medical assessment appointment.

The Registrar will refer most other claims, such as weekly benefits compensation, medical expenses, or where liability is disputed in relation to a claim for permanent impairment, to an Arbitrator for determination.

The following simple guide shows how the process works:

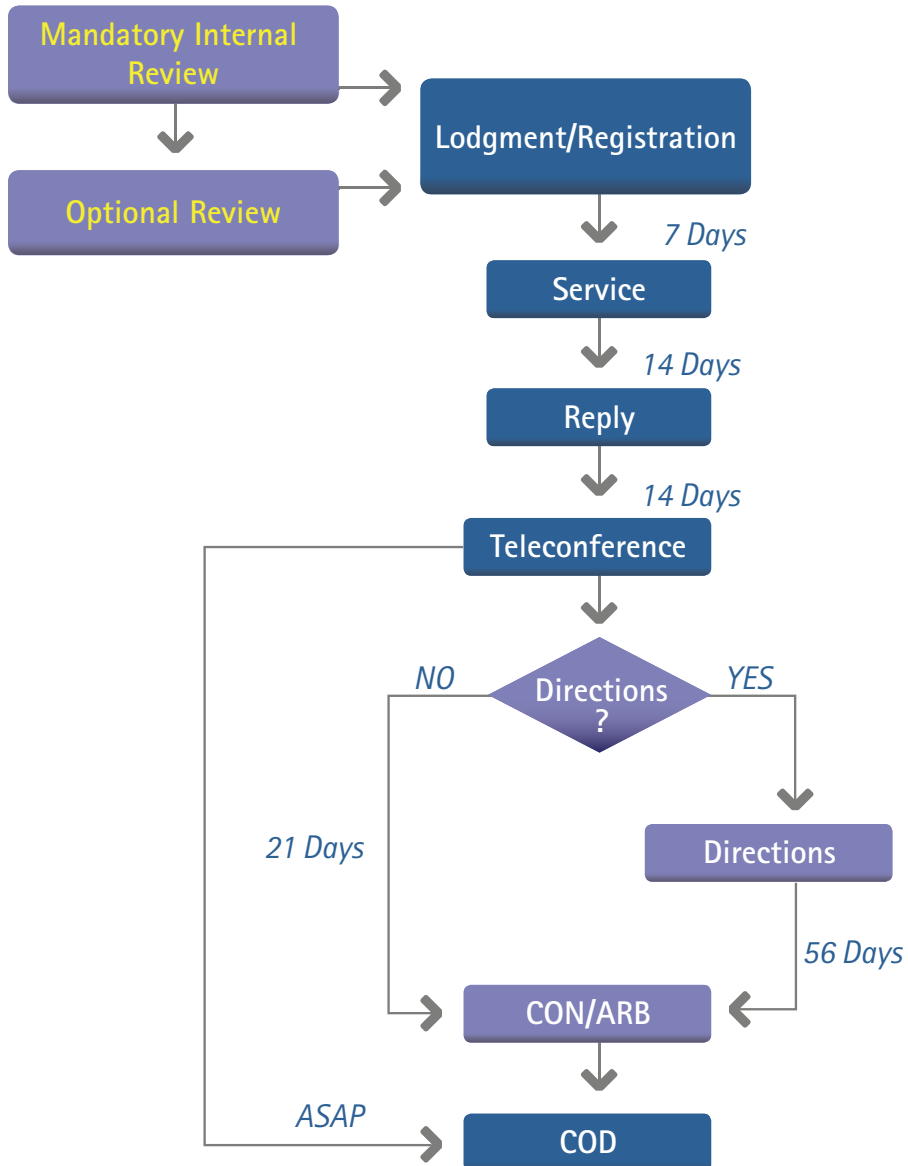


If a dispute is referred to an Arbitrator, a telephone conference (teleconference) will initially be held. If the dispute does not resolve, or the parties do not settle at the teleconference, the Arbitrator may set the matter down for a face-to-face conference meeting called the conciliation conference/arbitration hearing.

Arbitrators are trained to conduct Commission proceedings in a way that is fair to all the parties. At every stage of the process, Arbitrators encourage and assist the parties to resolve their dispute. However, if the parties fail to resolve it, the Arbitrator will determine the dispute.

Parties are encouraged to settle their dispute at any time during the process.

Progress of a general dispute in the workers compensation commission



Teleconference

When an Application to Resolve a Dispute is registered by the Commission, a proceedings timetable is issued to the parties. *(Note: Disputes regarding the degree of permanent impairment may be referred directly by the Registrar to an Approved Medical Specialist.)*

The timetable contains the teleconference date. The Commission schedules teleconferences approximately 35 days after the date of registration.

The Commission books the teleconference using the details provided by the parties in the Application and the Reply. Written confirmation of the date and time for the teleconference is sent to all the parties.

A teleconference is conducted by an Arbitrator and involves the worker, his or her legal representative, the employer, the insurer and the insurer's legal representative. The worker can participate in the teleconference from home or from his or her legal representative's office.

The teleconference is the first opportunity for the Arbitrator to bring the parties together and initiate discussion of the dispute. The Arbitrator will ask the parties about the dispute, identify the relevant issues and encourage the parties to reach an agreement.

During the teleconference, the Arbitrator will confirm:

- the willingness of all the parties to proceed;
- the likelihood of settlement;
- that all the parties understand the process;
- whether everyone agrees on the statement of facts or issues;
- any legal or threshold issues that must be decided; and/or
- any recent developments that may not be reflected in the documents.

If the parties reach an agreement, the Arbitrator will record the agreement in a Certificate of Determination. The Commission will then issue the Certificate of Determination to the parties.

If the Arbitrator cannot bring the parties to an agreement, the Arbitrator may decide that the dispute can be determined on the basis of the documents provided. This is called a 'Determination on the Papers' and can occur after the dispute has been discussed with all the parties, and after the parties' views have been noted at the teleconference.

If the parties do not reach an agreement and the dispute cannot be determined on the papers, the matter will be scheduled for a conciliation conference/arbitration hearing. At this stage, the Arbitrator will also consider submissions from the parties as to the need for issuing directions for the production of documents.

Conciliation Conference

If the dispute was not resolved at the teleconference, the Arbitrator will arrange a face-to-face meeting between the parties. The first part of this meeting is called a conciliation conference.

Conciliation conferences are typically scheduled to occur about 21 days from the date of the teleconference, unless the Arbitrator permits the issuing of directions to produce documents. If directions to produce documents are issued, the conciliation conference will be scheduled to occur after the directions have been dealt with and completed.

The Arbitrator will let the parties know whether to bring witnesses to the conciliation conference and what they need to do before and during the conference.

If the worker lives in Sydney, the meeting will be held in the metropolitan area. If the worker and/or his or her legal representative live in regional New South Wales, the Commission will arrange the conciliation conference according to its venue policy.



At the conciliation conference, the Arbitrator will explore the possibility of reaching an agreement on the dispute. The meeting could cover matters such as:

- a summary of the dispute;
- further discussion about the issues identified;
- possible outcomes that can be achieved for and by each party; and/or
- negotiation of an outcome that is acceptable to all the parties.

Every effort is made to have the parties settle by agreement.

If the parties reach an agreement during the conciliation conference, the Arbitrator will record the agreement in a Certificate of Determination, which the Commission will issue to the parties in due course.

If the parties are unable to reach an agreement about the dispute, the Arbitrator will terminate the conciliation conference and call for a short intermission. After the break, the Arbitrator will commence the arbitration hearing.

Generally, conciliation conferences will run for around 30 minutes. However, if the parties are engaged in beneficial and profitable discussions, they can continue with the conference until all the issues have been discussed.



Arbitration Hearing

If the dispute fails to settle at the face-to-face conciliation conference, then it moves into a more formal phase – the arbitration hearing.

This occurs on the same day, following the conciliation conference. The parties will be given a short break after the conciliation conference, after which the Arbitrator will commence the arbitration hearing. The proceedings are informal, but the hearing is recorded and is open to the public. (Parties may obtain a copy of the sound recording of the arbitration hearing by contacting the Registry.)

The Arbitrator will review what has occurred and get all parties to agree on a full and correct summary of the issues that are still in dispute.

If necessary, evidence can be taken under oath or affirmation either in person, by telephone conference or videoconference.

The parties can make an agreement to settle the matter at any time before the Arbitrator makes a decision. All the Commission's processes have been designed to allow the parties to reach a settlement at any stage of the proceedings.

If the parties are unable to come to an agreement, the Arbitrator will make a legally-binding decision about the dispute. The Arbitrator may advise the parties of the decision at the end of the hearing. More commonly, however, the Arbitrator will reserve his or her decision, and a Certificate of Determination and Statement of Reasons will be issued, usually within 21 days of the hearing.

The arbitration hearing is generally scheduled for three hours, but it can exceed that period, depending on the complexity of the issues and the progress of settlement discussions.

All arbitration hearings are sound-recorded. A transcript of the proceedings is made available to the parties free of charge in the event of an appeal from the decision of the Arbitrator.

Case Study

Mr S had worked as an aged care nurse for six years and alleged an injury occurred to his back on 12 May 2008 when assisting a patient to transfer from a bed to a wheelchair.

Mr S lodged an Application to Resolve a Dispute in relation to a claim for weekly benefits and medical expenses resulting from the alleged injury.

The dispute involved an ongoing claim for weekly benefits compensation from 18 October 2010 and medical expenses incurred for surgery performed to alleviate a disc protrusion.

Liability for the claim was disputed by the employer on the basis that Mr S had recovered from the effects of the injury and that the surgery was not reasonably necessary.

At a teleconference before an Arbitrator, the parties were unable to reach a settlement and the matter was listed for a conciliation/arbitration conference. The parties agreed that no Directions for Production were required and neither party would seek to lodge any late documents.

The parties were unable to reach agreement during the conciliation phase of the conference.

The Arbitrator formally heard the matter and granted leave for the respondent to cross-examine Mr S.

In a reserved decision issued to the parties three weeks after the arbitration hearing, the Arbitrator determined that Mr S had an ongoing partial incapacity for work and awarded weekly benefits compensation. The Arbitrator further determined that the applicant was entitled to the medical expenses associated with the surgery.

Arbitral Appeals

The President is responsible for the operation of the internal arbitral appeal process in the Commission.

Appeals from decisions of the Commission constituted by an Arbitrator are made to Presidential members pursuant to s 352 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act).

An appeal against an Arbitrator's determination made on or after 1 February 2011 is limited to the determination of whether the decision appealed against was or was not affected by an error of fact, law or discretion, and the correction of any such error. It is no longer a review of the decision appealed against.

The President, the two Deputy Presidents and the part-time Acting Deputy Presidents, sitting alone, hear and determine appeals from arbitral decisions.

If the Presidential member is satisfied that he or she has been provided with sufficient information, the appeal can be determined on the documentary material without holding a conference or formal hearing. While the majority of arbitral appeals are determined 'on the papers', a number of appeals require a full hearing.

Determinations by Presidential members are final, subject only to appeal on a point of law to the Court of Appeal (see s 353 of the 1998 Act).

Decisions of the Court of Appeal under s 353 are binding on the Commission and all parties to the proceedings to which the appeal relates.

Pre-filing Strike Out Applications

Workers who allege injury as a result of their employer's negligence may bring court proceedings to recover work injury damages. Before a claimant can commence proceedings for the recovery of work injury damages, he/she must serve a pre-filing statement. Under s 151D, proceedings cannot be commenced more than three years after the date of injury, except with the leave of the court in which the proceedings are to be taken. Time does not run in certain circumstances, including while a pre-filing statement remains current.

The President hears applications filed by defendants to strike out pre-filing statements served in claims for work injury damages (see s 315 of the 1998 Act and s 151DA(3) of the *Workers Compensation Act 1987*).

Questions of Law

The President hears and determines questions of law. The President may grant leave for a question of law to be referred for his opinion, either by the Arbitrator's own motion or after an application by a party to the Arbitrator. Under s 351(3) of the 1998 Act, the President is not to grant leave for the referral of a question of law unless he or she is satisfied that the question is novel or complex. In determining whether or not to grant leave to refer a question of law, the President will take into account, among other things, whether the question involves an interpretation of legislative provisions not previously considered at a Presidential or appellate level. Consideration must also be given to the objectives of the Commission.

Despite a reference of a question of law to the President, the Arbitrator will, wherever possible, continue to progress the proceedings. The exception to this course will be where the question of law concerns the Arbitrator's jurisdiction to make a determination (s 351(4) of the 1998 Act).

Case Study

Mr F was a serving police officer from February 1995 until August 2007. He alleged that, during the course of his employment, he was exposed to a series of traumatic events which resulted in a post-traumatic stress disorder.

Mr F made a claim for lump sum compensation under s 66 of the 1987 Act in respect of a 21 per cent permanent impairment relating to the psychological injury. The police force denied the claim and an application to resolve the dispute was lodged with the Commission.

In the early stages of the dispute proceedings before the Arbitrator, it became clear that the issue between the parties concerned the application of the transitional provisions found in Sch 6 Pt 18C cl 3(2) of the 1987 Act, which accompanied the amendments to the Act introducing lump sum compensation for psychological injury from 1 January 2002.

The transitional provisions provided that there be a reduction in the compensation payable for the proportion of the permanent impairment that was a previously non-compensable impairment.

In order to assess the reduction in the compensation payable, the parties identified two methods that had been applied in various decisions in the Commission and the former Compensation Court. The parties identified this dispute as a question of law and requested that it be referred to the President of the Commission pursuant to s 351 of the 1998 Act. Accordingly, the matter was referred to the President for consideration for determination of the question of law.

The President identified the alternative approaches as follows. Under the first method, the "reduction by lump sum method", the following approach is taken:

- a. a determination is made of the whole person impairment;*
- b. if the impairment found is over 15 per cent (the threshold required by s 65A of the 1987 Act for the payment of lump sum compensation for psychological injury), a determination is made of the lump sum payable in respect of the percentage impairment found;*
- c. if there is a previous non-compensable impairment, a determination is made of the proportion of any "previously non-compensable impairment";*
- d. apply by way of a reduction, in dollar terms, the non-compensable proportion found in (c) to the lump sum payable in respect of the whole person impairment determined at (b).*

The alternative approach, the "reduction in the percentage whole person impairment method", applies the following methodology:

- a. a determination is made of the whole person impairment;*
- b. a determination is made in percentage terms of any "previously non-compensable impairment";*
- c. a deduction is made, in percentage terms, of the non-compensable proportion found in (b) from the whole person impairment found in (a);*
- d. if the remaining whole person impairment is less than 15 per cent, no compensation is payable in accordance with s 65A(3) of the 1987 Act.*

After considering submissions from the parties and from WorkCover, who intervened in the proceedings pursuant to s 106 of the 1998 Act, the President determined that the transitional provisions addressed the issue of the "compensation payable" to ensure that the lump sum compensation is only payable for so much of the impairment that has resulted from the events that occurred after the introduction of the expanded benefits on 1 January 2002. A purposive interpretation of the provision, as required by s 33 of the Interpretation Act 1987, achieved that end.

The President answered the question of law as follows:

"The reduction for any proportion of the permanent impairment found to be a previously non-compensable impairment referred to in Sch 6 Pt 18C cl 3(2) of the 1987 Act is to be effected by a reduction 'in the compensation payable' and not by a reduction in degree of whole person impairment."

The employer has lodged a Notice of Appeal and the matter is now before the NSW Court of Appeal.

Common Law – Mediation

The Commission's role in work injury damages claims is limited to providing an administrative and mediation framework, together with a process for determining if the degree of whole person impairment is sufficient to meet the threshold for the recovery of damages.

In most cases, a claimant must refer a claim for work injury damages for mediation at the Commission before court proceedings can be commenced. A defendant may only decline to participate in mediation where liability is wholly denied.

Where a claim proceeds to mediation, the Registrar will appoint a Mediator. All parties, including the worker and the insurer, are required to attend the mediation.

The Mediator must use his or her best endeavors to bring the parties to agreement on the claim. If the parties fail to reach agreement, the Mediator will issue a certificate to that effect and the parties may then proceed to court.

Case Study

Ms Y worked as a sales representative for a carpet company. She alleged that, when unloading samples from the company car at a trade show, she suffered serious injury to her neck, with radiating pain to her left arm.

Ms Y alleged negligence on the part of her employer in that the employer failed to take proper care for her safety and failed to provide a safe system of work, and suitable and proper equipment.

In the pre-filing defence, the defendant denied the allegations and argued that Ms Y contributed to her injury by her own negligence, by failing to exercise due care for her own safety by not utilising the equipment provided to unload the samples from the car.

The matter proceeded to a mediation conference. With the assistance of a Mediator, the parties reached a final settlement and agreed terms at the conclusion of the mediation.

Medical Assessments

Medical disputes are generally referred to an Approved Medical Specialist for assessment. Approved Medical Specialists are appointed by the President of the Commission to provide an independent medical assessment relating to a work-related injury.

The Registrar will refer disputes regarding the degree of permanent impairment directly to an Approved Medical Specialist. Referrals are made by delegates of the Registrar.

The Approved Medical Specialist will usually examine the worker before issuing a Medical Assessment Certificate.

The following matters in assessments certified by an Approved Medical Specialist are conclusively presumed to be correct in proceedings before the Commission:

- The degree of permanent impairment of the worker as a result of an injury;
- Whether any proportion of permanent impairment is due to any previous injury or pre-existing condition or abnormality;
- The nature and extent of loss of hearing suffered by a worker;
- Whether impairment is permanent; and
- Whether the degree of impairment is fully ascertainable.

Case Study

Mr M lodged a claim for 16 per cent permanent impairment to the lumbar spine and left upper extremity resulting from a fall at work. The Respondent disputed liability and so the matter was referred to an Arbitrator to conduct a teleconference and subsequent conciliation.

Consent orders were entered following the conciliation, in which the claim was amended to include injury to the lumbar spine and 'a consequential injury to the left upper extremity as a result of treatment to the lumbar spine'.

The Registrar subsequently referred the dispute to an Approved Medical Specialist (AMS). The AMS reviewed the medical evidence lodged by both parties and examined Mr M.

The AMS issued a Medical Assessment Certificate (MAC) assessing seven per cent whole person impairment for the lumbar spine and four per cent permanent impairment of the left upper extremity, with a combined total of 11 per cent. As the claim reached the threshold for pain and suffering compensation, the matter was referred back to the original Arbitrator, who was able to facilitate a final resolution with the parties in a post-MAC teleconference.

Appeals Against Medical Assessments

Registrar's Gatekeeper Function

A party who is not satisfied with the determination of a medical dispute in a medical assessment by an Approved Medical Specialist (AMS) may lodge an Application to Appeal Against the Decision of the AMS, pursuant to s 327 of the 1998 Act.

Following registration of the medical appeal application and the exchange of submissions between the parties, the Registrar has a legislative requirement to exercise a "gatekeeper" function of determining if a ground of appeal as specified in s 327(3) of the 1998 Act has been made out in the submissions supporting the medical appeal application. Solicitors in the Legal and Medical Services Branch perform the "gatekeeper" function under delegation of the Registrar.

An appellant may rely on all or any one of four grounds of appeal. The majority of medical appeals rely on the ground that there is a "demonstrable error" contained in the Medical Assessment Certificate.

If the medical appeal application is made on the ground of appeal that either the assessment was made using incorrect criteria (s 327(3)(c)) or that the Medical Assessment Certificate contains a demonstrable error (s 327(3)(d)), or both, the application must be made within 28 days after the issuing of the Medical Assessment Certificate.

If the Registrar is satisfied that a ground of appeal is made out, the medical appeal application is referred to a Medical Appeal Panel constituted by the delegate. The Registrar may refer the matter to either the original AMS or another AMS for further assessment or reconsideration as an alternative to an appeal, pursuant to ss 326 and 329 of the 1998 Act.

Case Study

A worker lodged an Application to Resolve a Dispute, seeking compensation for injuries to his right upper extremity. The Registrar referred the matter to an AMS for assessment of the worker's degree of permanent impairment.

The AMS assessed the worker as suffering nil per cent whole person impairment. The worker lodged a medical appeal against the decision of the AMS on the basis that there was additional relevant information available, pursuant to s 327(3)(b) of the 1998 Act. The alleged additional relevant information consisted of two doctors' reports and a statement made by the worker.

Both of the doctors' reports were dated prior to the date of the assessment. The Registrar's delegate found that the worker's submissions did not establish that the reports were not available to and could not reasonably have been obtained before the assessment.

*Having regard to the judicial decisions in *Pitsonis v Registrar Workers Compensation Commission* [2008] NSWCA 88 and *NSW Police Force v Fleming* [2010] NSWSC 216, the Registrar's delegate determined that the worker's statement was not available to the worker and could not reasonably have been obtained before the assessment because it commented on the assessment process undertaken by the AMS. However, the delegate found that the significance of the statement alone did not warrant allowing the appeal to proceed because it offered little that would assist a Medical Appeal Panel in coming to a different assessment than that of the AMS.*

The Medical Appeal Panel

The role of the Medical Appeal Panel is to conduct a review of the grounds of appeal raised by the appellant. However, it may also review other grounds of appeal, if it gives the parties an opportunity to be heard on those grounds. Recent legislative developments have restricted the nature of considerations undertaken by Medical Appeal Panels in relation to medical appeals. The *Workers Compensation Legislation Amendment Act 2010* now restricts the matters to be determined by Medical Appeal Panels to the grounds of appeal on which the appeal was made.

Medical Appeal Panels are comprised of an Arbitrator and two AMSs.

Currently, seven Arbitrators and a number of AMSs conduct medical appeals. The full list can be found in Appendix 4.

The Medical Appeal Panel reviews material available to the AMS and documents filed in the medical appeal proceedings, including any additional information relied upon by the appellant. Where appropriate, the Medical Appeal Panel may deal with the medical appeal 'on the papers' without further submissions from the parties; or, the Medical Appeal Panel may decide to conduct a re-examination of the worker. It may also hold an assessment hearing where the parties may make oral submissions.

The Medical Appeal Panel must provide adequate reasons for determining the issue of whether or not to conduct a re-examination or a hearing, or to deal with the medical appeal on the papers.

The *WorkCover Medical Assessment Guidelines* and s 328 of the 1998 Act set out the procedures undertaken by Medical Appeal Panels in dealing with medical appeals.

The Medical Appeal Panel, like the AMS, is bound by the original AMS referral and the provisions in s 326 of the 1998 Act in relation to the status of medical assessments. Like the AMS, the Medical Appeal Panel's role and function in medical assessments is to ascertain the degree of permanent impairment of the worker, as assessed. This includes the determination of any proportion of permanent impairment that is due to a previous injury or pre-existing condition or abnormality.

Case Study

The worker claimed he suffered a psychological injury as a result of the nature and conditions of his employment as a police officer. The Registrar referred the matter to an AMS for assessment of the degree of whole person impairment. The AMS assessed the worker as suffering from 24 per cent whole person impairment.

The employer lodged an Application to Appeal Against the Decision of an AMS alleging that the assessment was made on the basis of incorrect criteria, that the Medical Assessment Certificate (MAC) contained a demonstrable error, and that additional relevant information was available.

The employer sought to adduce fresh evidence of an online printout of the website page for a company that listed the worker as a franchisee. The employer claimed the evidence was relevant to the assessment because the worker had stated to the AMS that he was not employed, and that the evidence was not available until after the assessment because the employer had only become aware of the worker's connection with the company after it had attempted to contact him through his mobile telephone. The call was diverted to a recorded message that brought the franchise employment to their attention. The worker claimed that he did not mention the franchise in the examination because he was not earning any money from it and therefore did not regard himself as employed.

The employer submitted that:

- *there were errors in the AMS's assessment in terms of the worker's employability because his assessment in this category under the Psychiatric Impairment Rating Scale (PIRS) was inconsistent with the worker having previously worked as a carpet cleaner and currently as a franchisee;*
- *the AMS's finding that the worker suffered a moderate impairment in the PIRS category of Travel was against the evidence that he had recently purchased a new Harley Davidson motorcycle and had travelled significant distances alone; and*
- *the AMS's assessment of the worker as suffering from a mild impairment in the PIRS category of Social Functioning was inconsistent with the evidence of the worker checking his Facebook account, going out to dinner with his wife once a week, and occasionally going to the pub with friends.*

The Medical Appeal Panel received the fresh evidence and found, on the face of all the evidence already available to the AMS at the initial assessment, that, while the worker was unable to work as a police officer, he was able to work in a different and less stressful environment.

The Medical Appeal Panel revoked the original MAC and conducted its own assessment. It found that the worker suffered from a lesser impairment than that found by the AMS in the PIRS categories of Self Care and Personal Hygiene, Travel, Concentration and Persistence and Pace, and Employability. The Medical Appeal Panel issued a new MAC assessing the worker as suffering from seven per cent whole person impairment.

Costs Assessments

The general costs order in the Commission is that costs are to be as agreed or assessed. Failing agreement, application may be made to the Registrar to assess costs. Applications may be made for party/party costs, solicitor/client costs or agent/client costs and disputes as to apportionment between former and current legal representatives. Assessments are undertaken by delegates of the Registrar. Costs may be in respect of workers compensation claims or common law claims.

Assessments of costs are regulated under Pt 17 of the *Workers Compensation Regulation 2010*, with the main instrument of costs provisions contained in Schs 6 and 7.

Consideration of other costs and disbursements may also require a reference to other pieces of legislation, such as the *Legal Profession Act 2004*, the *Legal Profession Regulation 2005* and the *Motor Accidents Compensation Regulation 2005*.

The Commission publishes all costs assessment decisions on the Commission's website at www.wcc.nsw.gov.au.

Case Study

The former lawyers of the worker lodged an application for assessment of costs in order to ascertain their entitlement to a portion of professional costs paid or payable to the current lawyers of the worker, following successful resolution of the claim or proceedings in the Commission.

The former lawyers claimed that the costs must be apportioned between them and the current lawyers, pursuant to cl 98(3) of Pt 17 of the Workers Compensation Regulation 2010, because they had provided legal work to the worker prior to negotiating with the insurer or to the commencement of proceedings in the Commission, at which time the current lawyers assumed conduct of the claim.

Following receipt of instructions from the worker, the current lawyers provided the former lawyers with the worker's authority to release or transfer the client file and an undertaking to protect or negotiate with the other party the costs incurred thus far by the former lawyers.

In acknowledging the undertaking, the former lawyers posed a condition that payment of the medical report fee of their own qualified doctor was to be firstly made, before the client file would be transferred to the current lawyers.

The current lawyers provided another undertaking, ensuring that they would include the medical report fee in their negotiations with the other active party in the event that the worker's claim was successful.

The former lawyers did not transfer the client file to, and did not serve a copy of the medical report on, the current lawyers, the latter having decided not to make the conditional payment for the report. The worker successfully pursued his claim without commencing proceedings in the Commission and the current lawyers received payment of professional costs and disbursements from the employer's insurer. The issue before the costs assessor was whether or not the former lawyers were entitled to a proportion of the costs paid to the current lawyers upon successful resolution of the claim.

The costs assessor determined that due to the conduct of the former lawyers – of not transferring the client file or serving the qualified doctor's medical report, despite the authority furnished by the worker and the undertakings provided by the current lawyers – the current lawyers never had the benefit of relying on the former lawyers' file and reports, and were compelled to provide the necessary legal services afresh, including the procurement of their own qualified medical reports. The work performed by the former lawyers therefore was not instrumental in obtaining the favourable resolution of the claim.

The costs assessor also found that the current lawyers provided sufficient and appropriate undertakings to protect the former lawyers' costs, forming the view that the former lawyers' conduct of not delivering the file because the medical report fee had not been paid as a condition to be met before the file could be transferred was unfair and unreasonable.

The costs assessor found that the former lawyers attempted to secure their costs entitlements without being subject to the risks inherent in any party/party costs dispute to which the current lawyers were equally exposed, depending on the nature and resolution of the claim.

The costs assessor declined to apportion costs between the lawyers and found that the former lawyers were not entitled to payment of the medical report fee as a disbursement and to costs of the assessment.

Expedited Assessments

The expedited assessment process provides for faster resolution of disputes than the general dispute resolution process. Matters are set down for a teleconference with the parties. Teleconferences are usually conducted approximately two weeks after lodgment of the dispute application. Face-to-face conciliation conferences and arbitration hearings are not scheduled and there are no provisions to issue directions for production. The filing of a Reply is optional and submissions are usually finalised during the teleconference. The filing of written submissions is accommodated for the more complex disputes. Additional material is usually filed and served prior to the teleconference.

Expedited assessments are divided into three categories:

1. Interim Payment Directions;
2. Small Claims; and
3. Workplace Injury Management Disputes.

Delegates of the Registrar conciliate and determine these disputes.

1. Interim Payment Directions

Disputes concerning weekly payments of compensation of up to 12 weeks or medical expenses compensation up to \$7,651.60 as at 1 April 2011 and \$7,783.50 as at 1 October 2011 and are generally dealt with under the Interim Payment Direction (IPD) provisions (ss 297–304 of the 1998 Act).

An IPD is intended to ensure early intervention where an insurer fails to commence payment of compensation or fails to determine a claim within the required time, although an IPD may also be made when an insurer disputes liability and a dispute notice has been issued.

If a dispute fails to resolve at the teleconference, the Expedited Assessment Officer will determine the dispute by reference to the documents lodged and submissions made in the proceedings. If the dispute is determined in favour of the worker, the Expedited Assessment Officer will direct payment by the insurer, by way of an IPD. An Expedited Assessment Officer is to presume that an IPD is warranted in circumstances prescribed by the legislation. Decisions of Expedited Assessment Officers are not published.

The payment of compensation in accordance with an IPD is not an admission of liability by the insurer or employer.



Case Study

The employer arranged for the worker to attend a meeting at an off-site location. The meeting was held in a club. The employer provided a catered lunch.

In the process of consuming a sausage roll at lunch, the worker experienced pain in his mouth and assumed that he had broken his dental bridge.

The worker attended his dentist to remedy the problem he thought he had with the dental bridge.

An examination by his dentist revealed that the two teeth supporting the dental bridge had snapped at gum level and that the dental bridge itself had broken.

The worker claimed the cost of the dental treatment on the basis that he had injured himself in the course of employment or, alternatively, that he had suffered an injury in a recess.

Injury in the course of employment was not disputed. There was no dispute as to the reasonableness of the treatment administered or the fact that the treatment was reasonably necessary.

It was not disputed that the treatment would relieve significant pain or discomfort.

In these circumstances, if injury is established, then the issuing of an Interim Payment Direction (IPD) would be warranted.

The employer denied liability on the basis that employment was not a substantial contributing factor. The employer denied that the worker was on a recess when the injury occurred.

The only medical evidence available was the finding of the dentist that the presence of a hard object in the sausage roll could explain why the worker sustained the damage to his teeth.

As the worker had not left the premises where the meeting took place and, given the character of the meeting and the employer's encouragement of the employee to remain within the confines of the premises where the meeting was being held, it was determined that the worker was not on a recess when the injury occurred.

However, given that the worker was participating in activities directed, induced, and encouraged by the employer, it was held that the worker's employment was a substantial contributing factor to the worker's injury.

Having satisfied the presumption in favour of issuing the IPD, the employer was directed to pay the cost of the dental treatment.

2. Small Claims

In some cases, the Registrar may determine past weekly compensation benefits claims for a closed period of up to 12 weeks under the "small claims" provisions in ss 304A and 304B of the 1998 Act. Under the "small claims" provisions, the Registrar and her delegates may exercise arbitral functions and a dispute is determined by the issuing of a Certificate of Determination. The determination is subject to the appeal provisions in s 352 of the 1998 Act.

3. Workplace Injury Management Disputes

Workers, insurers and employers can apply to the Registrar to resolve disputes about workplace injury management where:

- There is no injury management plan or the plan has not been followed;
- There is no return-to-work plan or the plan has not been followed;
- Suitable duties have not been provided to the injured worker, and/or
- The worker's capacity to perform duties is in dispute.

A teleconference will usually be held by an Expedited Assessment Officer in the first instance. If the parties fail to resolve the dispute by agreement at the teleconference, the Expedited Assessment Officer may make a recommendation in relation to resolving the dispute.

The Expedited Assessment Officer may refer the matter to an Injury Management Consultant or other suitably qualified person to conduct a workplace assessment prior to the making of a recommendation. An Injury Management Consultant is a registered medical practitioner appointed by WorkCover NSW. The Injury Management Consultant uses his or her specialised skills to assist the worker, the worker's nominated treating doctor and the employer in relation to the worker's return to work and/or injury management plan.

The Expedited Assessment Officer, in making a recommendation to the parties for a certain course of action to be adopted in order to resolve the dispute, usually concludes a matter.

Case Study

The worker had been employed for approximately 11 years.

She claimed that she suffered an injury to her left shoulder as a consequence of the type and nature of her work.

The worker alleged that the employer had failed to provide suitable duties. The worker commenced proceedings in the Commission as an expedited assessment matter.

A vocational and functional assessment was undertaken. Several positions were identified. The employer claimed that it was not reasonably practicable to provide the nominated duties given the worker's physical restrictions.

It was agreed that an Injury Management Consultant (IMC) would be appointed in order to assess the worker and the workplace, to ascertain if suitable duties were available, and to identify any process required and associated with such duties.

The IMC assessed the worker as being fit to work her pre-injury hours.

In determining the application, the Expedited Assessment Officer recommended that:

- 1. A conference be held between the employer, the worker, her nominated treating doctor, and a rehabilitation provider to determine or match the suitable duties identified by the IMC and accommodate any changes to the worker's restrictions;*
- 2. The rehabilitation provider was to provide a return-to-work plan in relation to the suitable duties identified by the IMC;*
- 3. The rehabilitation provider was to assess the worker on-site as to the practical application of ergonomic principles to her work requirements, and to provide specific feedback to the worker;*
- 4. The rehabilitation provider was to maintain contact with the worker to ensure compliance with the principles required for a safe return to work; and*
- 5. If, in the opinion of the rehabilitation provider, the worker could not implement the ergonomic principles to her work requirements, then the rehabilitation provider was to formulate a return-to-work plan which involved suitable duties being sourced from another employer.*

Committees and Forums

The Commission utilises a variety of committees and forums to assist with decision-making and governance arrangements. The various committees and forums comprise a mixture of Commission members, staff, service partners and external users. They provide opportunities for information-sharing, consultation, and the development of options in relation to the operations of the Commission. A brief summary of several of the forums is outlined below.

AMS and Mediator Reference Groups

During 2011, the Commission continued to host Approved Medical Specialist (AMS) and Mediator Reference Groups. The reference groups meet quarterly and operate as advisory and consultative forums through which the Commission can provide information and obtain feedback from Commission service partners in relation to a variety of issues.

Matters dealt with by the AMS Reference Group in 2011 included:

- content of the Annual AMS conference program;
- feedback from the client survey;
- content of an AMS Practice Manual; and
- development of new performance reports for AMSs.

Membership of the Committees is revamped on an annual or bi-annual basis. During 2011, the Reference Groups comprised:

AMS Reference Group

Chair: Registrar Sian Leathem

Secretariat: Organisational Performance Unit

Dr Geoffrey Boyce

Dr Peter Burke

Dr Mark Burns

Dr Drew Dixon

Dr John Dixon-Hughes

Dr Philippa Harvey-Sutton

Dr Hunter Fry

Dr Roger Pillemer

Dr Brian Williams

Ms Lyn Martin, Manager Legal and Medical Support

Ms Mary Hawkins, WorkCover NSW

Mediator Reference Group

Chair: Registrar Sian Leathem

Secretariat: Organisational Performance Unit

Mr Marshal Douglas

Ms Geri Ettinger

Mr John Ireland

Ms Katherine Johnson

Mr Steve Lancken

Mr Ross MacDonald

Ms Margaret McCue

Mr John McDermott

Mr John McGruther

Mr Garry McIlwaine

Ms Janice McLeay

Ms Annette Farrell, Deputy Registrar

Ms Lyn Martin, Manager Legal and Medical Support

Matters dealt with by the Mediator Reference Group in 2011 included:

- content of Mediator professional development forums;
- feedback from the client survey; and
- strategies for encouraging respondents to fully participate in mediations.

User Group

The President chairs the Commission's User Group, which is composed of two full-time Deputy Presidents, a Senior Arbitrator, the Registrar, the Deputy Registrars and representatives from the NSW Bar Association, the Law Society of NSW and WorkCover.

During 2011, the membership was as follows:

Chair: President Judge Greg Keating

Secretariat: Margot Undercliffe/Penelope Fleming

Deputy President Bill Roche

Deputy President Kevin O'Grady

Registrar Sian Leathem

Senior Arbitrator Deborah Moore

Deputy Registrar Rod Parsons

Deputy Registrar Annette Farrell

Ms Mary Hawkins/Mr Cameron Player, WorkCover NSW

Mr Greg Beauchamp, barrister

Mr Steve Harris, solicitor

Ms Roshana May, solicitor

Mr Brian Moroney, solicitor

Ms Penny Waters, solicitor

The group meets three times a year and is an excellent forum for discussion and feedback on operational and procedural issues to ensure the Commission's practices and procedures are working efficiently and meeting stakeholder expectations.

Issues discussed during the 2011 meetings included the following:

- quality testing of medical reports;
- new practice direction on wages material;
- development of a new template for complying agreements; and
- injury management seminar program for insurers.

Arbitrator Practice Meetings

In late 2010, the Commission introduced bi-monthly Arbitrator Practice Meetings to provide regular information to Arbitrators and to seek their input on operational matters in the Commission. The meetings are open to all full-time, part-time and sessional Arbitrators, and are chaired by the Registrar.

During 2011, issues covered during the practice meetings included:

- feedback from the client survey;
- organisational and individual statistical information;
- new practice directions; and
- peer review.

Access and Equity

The Commission strives to ensure that all services are accessible and equitable for everyone. The *Access and Equity Service Charter* identifies the many ways the Commission achieves these goals:

Cost: Services to all parties are free.

Self-representation: Information on processes and procedures is made available to all parties either via the internet or in hard copy. A DVD is available for download and information leaflets are available in 11 languages. An e-bulletin is available on a quarterly basis.

Outreach: To assist self-represented workers, information is available either over the counter or by telephone once an application has been lodged.

Disability Access: All conference and meeting rooms are accessible to everyone, hearing loops are available in all rooms, and a TTY (text telephone) service is available.

Interpreters: Upon request, interpreters can be provided free of charge in the language or dialect requested.

Regional Communities: Arbitrators service regional and rural areas in an effort to allow hearings to be heard close to where workers reside.

Equity: The Commission has put in place strategies to ensure the making of equitable, fair, consistent and well-reasoned decisions. These include implementing the Code of Conduct and providing training to Arbitrators, Mediators and Approved Medical Specialists.

Effective Relationships: The Commission offers ongoing education and training seminars for key interest groups including employers, insurers, medical practitioners, trade union personnel and the legal profession.

Complaints Handling

The Commission's complaint handling policy and procedure is outlined in Part 5 of the Access and Equity Service Charter.

The Commission is committed to responding promptly and fairly to any comments or complaints about its range of services. However, it is important to be aware that dissatisfaction with the outcome of a dispute is not a matter that can be appropriately managed through the internal complaint handling process. Rather, there are statutory rights of appeal and reconsideration for parties who are aggrieved by a decision of the Commission. Parties are advised, wherever possible, to obtain legal advice before seeking an appeal.

Complaints can be made about the actions of Commission staff or Members, including Presidential Members, the Registrar and Arbitrators. Complaints may also be made about the actions of a Mediator or an Approved Medical Specialist. The Commission acknowledges that a prompt and considered response to suggestions and complaints about its practices and procedures can play an important role in improving services and creating confidence in the dispute resolution process.

Complaints about the actions of Commission Members, staff, Mediators or Approved Medical Specialists should be made in writing to the Registrar. If the complaint concerns the Registrar or a Presidential Member, it should be directed to the President for attention. Anonymous complaints cannot be accepted. Where a complaint is made verbally, a written response will not generally be provided. However, where appropriate, the Registrar will consider how matters raised in verbal complaints might inform improvements in the Commission.

Where a person has difficulty putting a complaint in writing, staff of the Commission can provide appropriate assistance.

The Registrar (or President) will investigate all written complaints and, where appropriate, may do one or more of the following:

- consider what, if any, prompt action may resolve the complaint and, where appropriate, institute or recommend such action;
- consult with the person who is the subject of the complaint;
- contact the complainant personally to attempt informal and speedy resolution of the complaint;
- refer the complaint to the President for consideration in relation to reviewing the performance of an Arbitrator, Mediator or Approved Medical Specialist;
- in the case of a staff member, recommend that some action be taken in accordance with public sector procedures; and/or
- initiate changes to practices or procedures to address the issues arising in the complaint.

Complaints Received in 2011

During the reporting year, the Commission received a total of 20 complaints. This represents around 0.1 per cent of all applications lodged in the Commission. Sixteen of the complaints concerned medical assessments conducted by Approved Medical Specialists. One complaint concerned an Arbitrator. The remaining three complaints concerned an issue of practice or procedure of the Commission.

All of the complaints were acknowledged in writing within seven days of receipt. All but two received a full written response within 28 days. Those matters were deferred as reconsideration applications were on foot at the time the complaints were received.

The Organisation

Members

The Commission currently consists of the following Members:

- The President – Judge Greg Keating
- Two Deputy Presidents – Bill Roche and Kevin O'Grady
- Two Acting Deputy Presidents – Tony Candy and Lorna McFee
- The Registrar – Sian Leathem
- Three full-time Senior Arbitrators – Eraine Grotte, Deborah Moore and Michael Snell
- 20 full-time equivalent Arbitrators (see Appendix 1)
- 17 sessional Arbitrators (see Appendix 1)

The Attorney General appoints the Members of the Commission.

President and Deputy Presidents

His Honour Judge Greg Keating is the President of the Commission. The President is the head of jurisdiction and works closely with the Registrar in the overall leadership of the Commission. The President is also responsible for the general direction and control of the Deputy Presidents and Registrar in the exercise of their functions.

The President, together with two full-time Deputy Presidents and two part-time Acting Deputy Presidents, constitute the Presidential Members of the Commission.

During 2011, the Commission was assisted in maintaining its timely resolution of appeals by Acting Deputy Presidents, Mr Anthony Candy and Ms Lorna McFee.

On 10 December 2011, Ms McFee was reappointed for a further 12 months. Mr Candy did not seek reappointment for 2012.

The Presidential members hear and determine appeals from decisions of Arbitrators. The decisions of Presidential Members may be appealed to the NSW Court of Appeal on questions of law only.

The President also has the responsibility of determining 'novel or complex' questions of law referred by Arbitrators. In relation to work injury damages matters, the President has exclusive jurisdiction to determine applications by defendants to strike out pre-filing statements.

Registrar

The Registrar is responsible for the administrative management of the Commission and is the functional head of the Commission's services.

The Registrar is directly responsible for providing high-level executive leadership and strategic advice to the President on the resources of the Commission, including human resources, finance, asset management, facilities, resources and case management strategies.

Deputy Registrars, Mr Rod Parsons and Ms Annette Farrell, and Manager of Executive Services, Mr Geoff Cramp, assist the Registrar.

In addition to the administrative responsibilities, the Registrar may exercise all of the functions of an Arbitrator. Further, the Registrar is responsible for the general control and direction of the Arbitrators in the exercise of their functions.

Senior Arbitrators

As key members of the Commission, Senior Arbitrators occupy a leadership role within the organisation.

Senior Arbitrators are responsible for the resolution and determination of disputes about workers compensation claims. They also assist the Commission in professional development, peer review, mentoring and appraisal of Arbitrators, case management, and the development of practice and procedure.

Arbitrators

Arbitrators work with the parties to explore settlement options and, where possible, reach an agreed resolution of the dispute. Arbitrators manage disputes through to finalisation, utilising a series of conferences, including either teleconferences and/or conciliation/arbitration conferences.

The Commission has 15 full-time Arbitrators (including three Senior Arbitrators) and four part-time Arbitrators. They are supported by 13 sessional Arbitrators, who are engaged on an independent contractual basis, to assist with regional matters and any excess workload in the metropolitan region.

In addition, there are four sessional Arbitrators, who are appointed solely to deal with medical appeals.

The Registrar may exercise all the functions of an Arbitrator. The Deputy Registrars also hold Arbitrator appointments.

A full list of the arbitral appointments appears in Appendix 1.

Service Partners

In addition to Arbitrators, the Commission utilises the services of Approved Medical Specialists and Mediators. These service partners are engaged on an independent contractual basis and are appointed by the President.

Approved Medical Specialists

There are approximately 140 Approved Medical Specialists located throughout New South Wales holding appointments with the Commission. Approved Medical Specialists are appointed by the President in consultation with the Workers Compensation and Workplace Occupational Health and Safety Council.

Approved Medical Specialists are highly-experienced medical practitioners from a variety of specialities. To be appointed, they must have completed the necessary training in the WorkCover guidelines to assess whole person impairment, and their application must have undergone a rigorous assessment for impartiality. In this way, the Commission can ensure that the Approved Medical Specialists will provide an independent and unbiased opinion about the medical condition or injury of a worker.

The Commission refers medical disputes, such as the degree of permanent impairment of the worker as a result of an injury, to an Approved Medical Specialist for assessment. The selected Approved Medical Specialist will examine the worker and consider the appropriate reports and documents in the file, and issue a Medical Assessment Certificate. An assessment of the degree of permanent impairment by an Approved Medical Specialist is binding on the parties.

A schedule of Approved Medical Specialists appears in Appendix 2.

Mediators

The Commission is responsible for mediating work injury damages claims referred to it under the Workplace Injury Management and Workers Compensation Act 1998 before court proceedings for such claims can be commenced.

The Commission is supported by 28 contracted Mediators. All of the Mediators on the panel have extensive experience in alternative dispute resolution, as well as knowledge of the workers compensation jurisdiction.

Mediators are required to use their best endeavours to bring the parties to a negotiated settlement. They conduct mediation conferences in the Commission's Oxford Street premises and in other regional locations when required.

A schedule of Mediators appears in Appendix 3.

Medical Appeal Panels

The *Workplace Injury Management and Workers Compensation Act 1998* endows the Commission with the internal appellate jurisdiction to hear appeals against an assessment by an Approved Medical Specialist. These medical appeals are determined by a Medical Appeal Panel, which is constituted by an Arbitrator and two Approved Medical Specialists. The Medical Appeal Panel reviews the original decision by the Approved Medical Specialist and either confirms the original Medical Assessment Certificate or revokes it and substitutes a new Certificate.

To maintain the timeliness and quality of the determinations in Medical Appeals, a number of Approved Medical Specialists hold appointment to sit on Medical Appeal Panels.

Currently, all Medical Appeal Panels are convened by sessional Arbitrators. There are four sessional Arbitrators who have been appointed solely to undertake Medical Appeals. A number of the other sessional Arbitrators assist with any excess workload.

A list of the Approved Medical Specialists who hear medical appeals is at Appendix 4.

Staff

The Commission's staff establishment is 113 full-time equivalent positions, in a number of units in the Commission, who are employed to carry out its functions. The staff range in grade from Grade 1 Clerks through to Senior Officers (Grade 2), as well as Legal Officers.

Presidential Unit

The Presidential Unit has four full-time and two part-time staff members in addition to the Presidential Members.

The Administrative Associates work closely with the Presidential Members, providing high level administrative support, and also assist the Research Associates in the case management of arbitral appeals, with the aim of streamlining case management and improving timeliness.

In addition to supporting the Presidential members, particularly in their decision-making capacity, the Research Associates undertake research, prepare papers, maintain an electronic index of presidential decisions as a resource for staff and Members, and contribute to legislative and rules review.

In 2011, the Presidential Unit continued to prepare and publish 'On Appeal', an electronic publication of headnote summaries of Presidential and Court of Appeal decisions. 'On Appeal' is published monthly on the website, providing all Commission stakeholders with access to this useful resource.

The Unit also coordinates and provides secretariat support for the Commission's User Group. The President chairs the group, which consists of Presidential Members, the Registrar, the Deputy Registrars, Senior Arbitrators, members of the legal profession and a representative from WorkCover.

The Presidential Unit also organises the Annual Inter-Jurisdictional Personal Injury Dispute Resolution Tribunal meeting. The meeting is chaired by the President and consists of members and staff of workers compensation dispute resolution tribunals from Australia and New Zealand. It is held in conjunction with the AIJA/COAT national conference.

The Unit and the Commission's Research and Information Officer work together to ensure the timely publication of all Presidential decisions to AustLII. The Unit liaises with the editors of the Dust Diseases and Compensation Reports in the reporting and headnoting of Court of Appeal decisions and Presidential decisions.

Organisational Strategy Branch

The Organisational Strategy Branch is responsible for planning, strategy and organisational development. The Branch comprises the Registrar's Office, the Executive Unit and the Organisational Performance Unit.

Registrar's Office

The Registrar's Office is responsible for a range of functions, including the coordination of responses to Ministerial, WorkCover and stakeholder inquiries, the issuing of Medical Certificates of Determination, the management of complaints against Arbitrators, Mediators, Approved Medical Specialists and staff, and the coordination of presentations to internal and external audiences, including visiting delegations.

Executive Unit

The Executive Unit is responsible for the coordination of strategic and corporate planning processes, the preparation and monitoring of the Commission's budget, the provision of timely and accurate organisational data, risk management and audit functions, and the management of requests under the *Government Information (Public Access) Act*.

Organisational Performance Unit

Tasks undertaken in the Organisational Performance Unit include the coordination of training and development for staff, the management of appraisal processes for Arbitrators, Mediators and Approved Medical Specialists, the management of appointments of service providers, the coordination of Reference Group meetings, and the publishing of internal and external communication materials.

Operations and Business Support Branch

The Operations and Business Support Branch, under the direction of Deputy Registrar Annette Farrell, manages the client services and business support functions within the Commission. The Branch has five units, including Registry Services, Dispute Services, Operations Support, Business Services and Information Systems.

Registry Services

The Registry is the first point of contact with the Commission for workers, insurers, legal representatives and the general public.

Dispute Services

Dispute Services staff are responsible for the case management of applications for dispute resolution from the end of the information exchange period to closure of the matter, excluding appeals. The Unit is also responsible for case management of applications for mediation in work injury damages claims.

Operations Support

The Operations Support Unit initiates and undertakes service improvement projects across the Registry and Dispute Services units, develops and maintains business processes and procedures, and undertakes audit and risk management functions within the operational areas.

The Unit is also involved in the implementation of legislative amendments and policy changes affecting operational practice.

Business Services

The Business Services Unit manages finance processing and purchasing, facilities and records of the Commission.

Information Systems

The Information Systems Unit provides support for the Commission's case management system and other IT applications and equipment.

The Unit operates a help-desk facility for staff, members and service providers in relation to the case management system and to the general public for the Commission's online lodgment facility, e-Screens.

Legal and Medical Services Branch

The Legal and Medical Services Branch is under the management and direction of Deputy Registrar Rod Parsons.

The Branch is comprised of six units: a Legal Unit, Legal and Medical Support Unit, Expedited Assessments Unit, Administrative Support Unit (Legal), Arbitrator Support Unit and the Research and Information Unit.

The Branch performs a wide range of legal and administrative functions, including providing legal advice to Members and staff, undertaking various legal and quasi-legal functions, and the ongoing professional development of Arbitrators and Approved Medical Specialists.

The Branch also maintains various significant resources for Members and staff of the Commission, Approved Medical Specialists, and legal practitioners, including 'On Review' and the Arbitrator Practice Manual. The Branch is currently developing a practice manual for Approved Medical Specialists. In addition, the Branch prepares legal research briefs, papers and bulletins, and provides legal advice regarding the operation of the legislation and proposed changes.

The Branch is responsible for developing ongoing education programs for Arbitrators and Approved Medical Specialists, including annual conferences and periodic forums. Legal members of the Branch also present at legal conferences and participate with WorkCover and insurance stakeholder representatives on the Injury Management Seminars Program.

Legal Unit

The Legal Unit is chiefly responsible for managing applications for:

- medical appeals;
- costs orders;
- costs assessments;
- defective pre-filing statements;
- orders for information and access to premises;
- orders in claims for benefits following the death of a worker; and
- various other claims or disputes.



The Legal Unit is also responsible for case management and the administrative requirements of judicial review and Court of Appeal actions in relation to medical assessments, medical appeals and various decisions made under delegation of the Registrar, including providing case summaries to members.

Legal and Medical Support Unit

The Legal and Medical Support Unit is responsible for project management and resource development in support of performance frameworks designed for Arbitrators, Approved Medical Specialists and Mediators. This work involves membership of the relevant reference groups; provision of professional development opportunities to Arbitrators, Approved Medical Specialists and Mediators, and coordination of activities such as induction, mentoring, the Decisions Evaluation Committee, and peer review.

Expedited Assessments Unit

The Expedited Assessments Unit is responsible for resolving applications in relation to workplace injury management disputes, applications to cure a defective pre-filing statement where a dispute arises as to compliance with rules and provisions regarding pre-filing statements, interim payment directions, small claims, and applications for a certification by the Registrar of an amount to be paid for the purpose of recovery in a court of proper jurisdiction pursuant to s 362 of the 1998 Act.

Administrative Support Unit (Legal)

The Administrative Support Unit (Legal) is responsible for the case management and administration of various applications, representations and projects managed and dealt with by the respective units in the Legal and Medical Services Branch.

Arbitrator Support Unit

The Arbitrator Support Unit provides legal and administrative support to full-time and sessional Arbitrators.

The administrative support staff provide general administrative support and undertake proofreading of arbitral decisions prior to issuing.

Solicitors in the Unit provide legal support to Arbitrators by researching on points of law, preparing case summaries, contributing to legal research briefs, maintaining relevant legal resources, monitoring changes to legislation, proofreading Arbitrator decisions for legal, grammar and formatting issues, checking case citations and references, and assisting in the conduct of hearings when required.

Research and Information Unit

The Research and Information Unit is responsible for maintaining the Commission's research library. It is staffed by the Research and Information Officer, who works directly with Presidential and Arbitrator members and staff within and outside the Branch, ensuring that everyone has access to significant sources of legal information. The Unit also provides assistance to the legal profession and members of the public.



2011 WORKLOAD DISCUSSION

Registrations

During 2011, the total number of applications received by the Commission amounted to 12,076. This is an increase of four per cent from the total number of applications received in 2010.

The increase in applications was mostly due to a significant increase in mediation applications and a modest increase in applications to resolve a dispute.

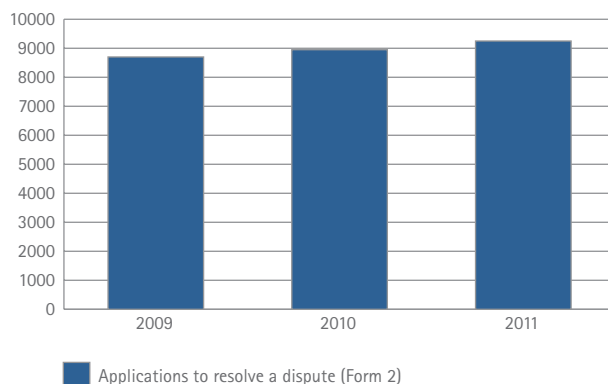
Application Type	2009	2010	2011
Application to Resolve a Dispute (Form 2)	8,707	8,921	9,225
Expedited Assessments (Form 1 and Form 1A)	586	516	505
Workplace Injury Management Dispute	124	139	112
Registration for Assessment of Costs	256	240	171
Commutations (Form 5A) and Redemptions (Form 5B)	267	227	220
Mediations (Form 11)	705	848	1,207
Arbitral Appeals (Form 9)	185	135	69
Medical Appeals (Form 10)	606	566	567
Total	11,436	11,592	12,076

Applications to resolve a dispute

There have been some minor variations in the numbers of Applications to Resolve a Dispute (ARD) (Form 2) lodged over the past three years. The number of applications filed over the last three years demonstrates a moderate yearly increase.

The monthly average of Form 2 applications increased from 750 per month in 2010 to 769 per month in 2011.

ARD Registrations 2009–2011



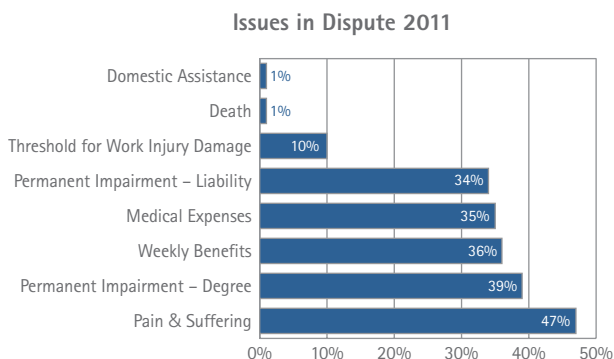
Issues in Dispute

Applications to Resolve a Dispute (ARDs) usually involve a dispute over more than one issue. For example, they may involve a claim for weekly benefits, a claim for medical expenses, and a claim for lump sum compensation for permanent impairment.

During the reporting year, 73 per cent of ARDs included a claim for permanent impairment compensation under s 66 of the *Workers Compensation Act 1987*. The dispute might relate to liability, the quantum of the permanent impairment, or both.

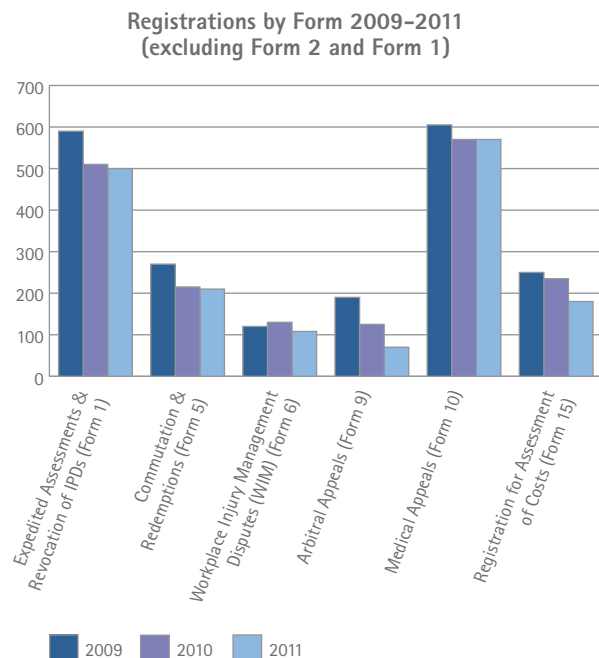
A total of 47 per cent of ARDs included a claim of compensation for pain and suffering under s 67 of the *Workers Compensation Act 1987*. Where an applicant is found to suffer a permanent impairment of 10 per cent or more, he or she has an entitlement to an amount of compensation for pain and suffering. The amount for the most extreme case is currently set at \$50,000.

A total of 36 per cent of ARDs included a claim for weekly benefits and 35 per cent of applications included a claim for medical expenses.



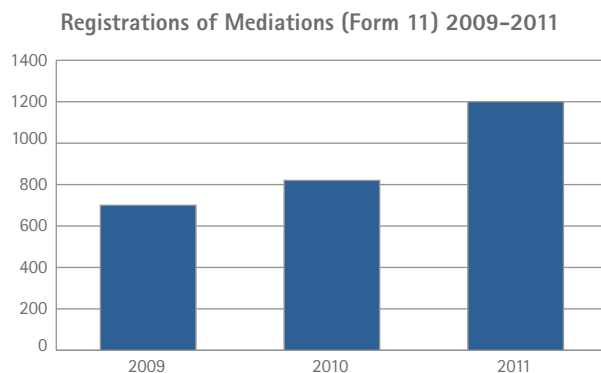
Other Applications

Mirroring the trend observed in 2010, in 2011 there was again a decrease in the number of Applications for an Interim Payment Direction (Form 1). There were also decreases in the number of Applications to Register a Commutation or Redemption (Form 5), Applications for an Assessment of Costs (Form 15) and Applications to Resolve a Workplace Injury Management Dispute (Form 6).



Mediations

As has been the case during the past three years, the number of Applications for Mediation to Resolve a Work Injury Damages Claim (Form 11C) continued to rise. In 2011, there was another significant increase of 42 per cent from 2010 levels, representing a cumulative increase of 71 per cent from 2009 levels.



Medical Appeals

In 2011, the number of Medical Appeals lodged in the Commission remained steady at 567.

The number of Medical Assessment Certificates issued increased from 4,379 in 2010 to 4,748 (an increase of eight per cent). The fact that there was not a similar increase in the number of Medical Appeals suggests an increase in the quality and durability of the Certificates issued by the Commission's Approved Medical Specialists.

During 2011, 567 Medical Appeals were lodged and 590 medical appeals were finalised.

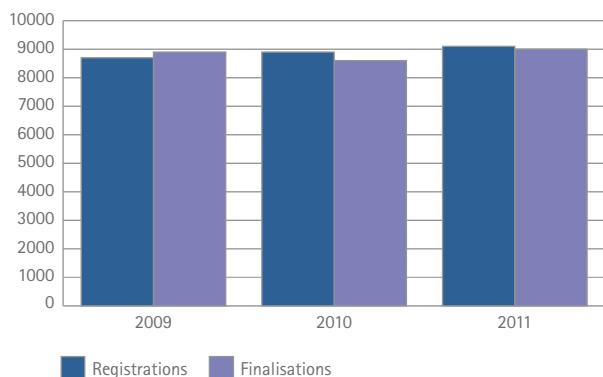
Arbitral Appeals

During 2011, 69 new applications to Presidential Members were filed and 74 applications were finalised. By the end of the year, the Commission had only 17 appeals pending.

In 2011, the Commission experienced a 49 per cent reduction in the number of appeals filed against arbitral decisions compared to 2010.

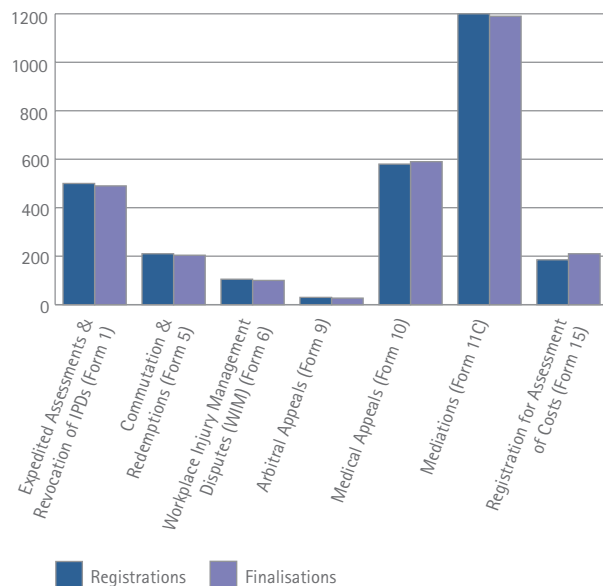
Finalisations

ARD Registrations vs Finalisations 2009–2011



Over the past three years, the number of ARD registrations and finalisations has fluctuated by a margin of approximately two to three per cent. This indicates both stability in the number of applications being filed and the capacity of the Commission to deal with the disputes.

Registrations vs Finalisations 2011
(excluding ARDs)



During 2011, the Commission finalised more of the following types of applications than it registered during the year:

- Arbitral appeals (Form 9);
- Medical appeals (Form 10); and
- Registration for Assessment of Costs (Form 15).

There were small deficits in the number of finalisations in the following types of applications:

- Applications to Resolve Dispute (Form 2);
- Applications for Mediation to Resolve a Work Injury Damages Claim (Form 11C);
- Workplace Injury Management Disputes (Form 6);
- Commutations and Redemptions (Form 5); and
- Expedited Assessments (Form 1).

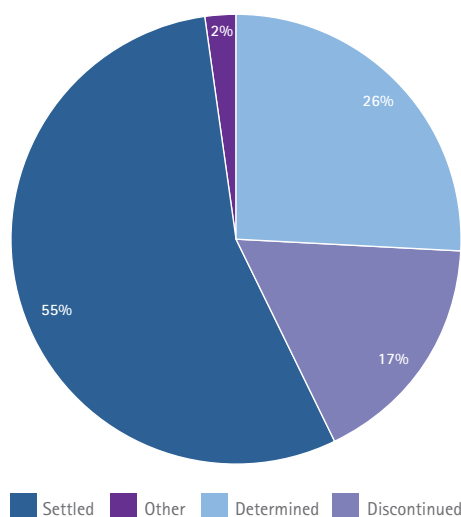
Outcomes

Applications to Resolve a Dispute

In 2011, 74 per cent of Form 2 applications were finalised without the need for a determination – that is, they were resolved by agreement between the parties or by some other means of finalisation.

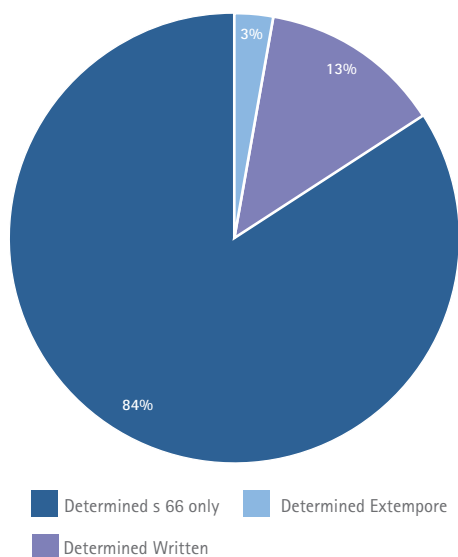
The settlement rate for ARDs increased during 2011 to a total of 55 per cent of ARDs, up from 53 per cent during 2010.

ARD Outcomes 2011



Of the 26 per cent of Applications to Resolve a Dispute (2,434 applications) that were finalised by a formal determination, more than 80 per cent (1,971 applications) of these involved the issuing of a Medical Certificate of Determination by the Registrar. These Certificates finalise an Applicant's entitlement to s 66 compensation following a medical assessment by an Approved Medical Specialist.

ARD Determined Matters



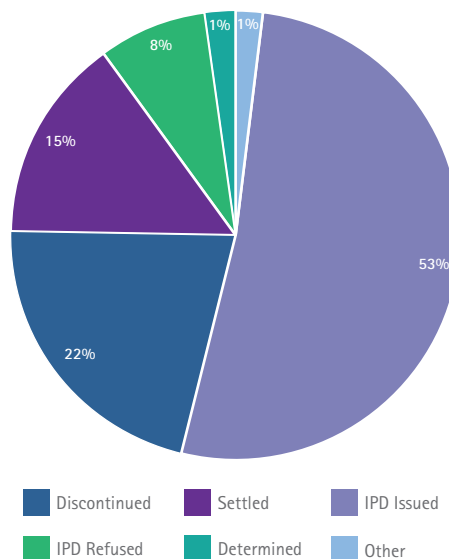
The proportions of written and extempore decisions made by Arbitrators during 2011 are similar to the proportions reported in 2010.

Expedited Assessments

In 2011, 53 per cent of Applications for Expedited Assessment resulted in an Interim Payment Direction (IPD) being issued. A further 15 per cent were settled, while 22 per cent were discontinued. In eight per cent of applications, an IPD was refused by the Expedited Assessment Officer.

The Expedited Assessment Officers also issued 73 recommendations in relation to 112 workplace injury management disputes.

Interim Payment Direction Outcomes



Medical Appeals

In 2011, there were a total of 567 medical appeals lodged, of which 483 proceeded to a Medical Appeal Panels following a gatekeeper determination.

The number of Medical Appeals rejected at the gatekeeper level increased to 107 in 2011 (representing around 18 per cent of the overall medical appeal resolutions), compared to 69 in 2010 (12 per cent of all resolved medical appeals).

Of the 483 that were determined by a Medical Appeal Panel, 223 confirmed the Medical Assessment Certificate, while 213 revoked the Medical Assessment Certificate. The remaining 47 appeals were withdrawn prior to determination by a Panel. Proportionally, this represents 38 per cent confirmations and 36 per cent revocations of all medical appeals resolved in 2011. This is a significant departure from previous years, in which there were more revoked Certificates.

The increased rate of confirmation of certificates on appeal, along with the increased number of applications where leave to proceed was not granted by the gatekeepers, supports an increase in the quality and durability of Medical Assessment Certificates issued by the Approved Medical Specialists and of a more thorough understanding of the medical assessment process by all parties concerned.

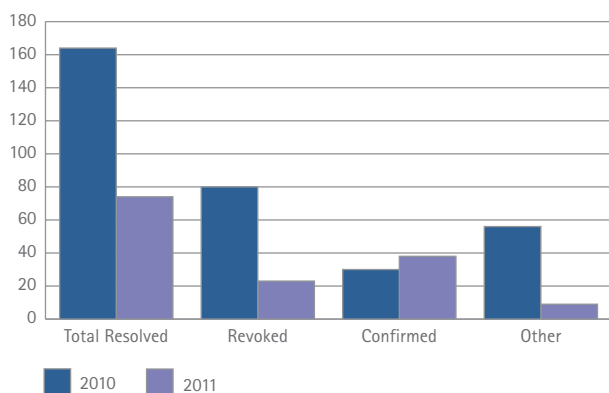
Arbitral Appeals

In 2011, 76 per cent of arbitral appeals were finalised by a Presidential determination. Seventeen per cent were settled or discontinued by the parties and the remaining seven per cent were rejected by the Registrar for procedural non-compliance.

There has been a significant reduction in both the number of arbitral appeals lodged and the revocations resulting from arbitral appeals.

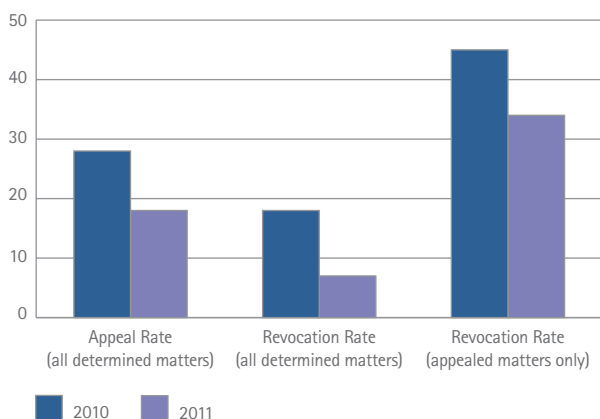
The chart below demonstrates the decrease in revocations and the increase in confirmations during the review period.

Arbitral Appeal Outcomes 2010 & 2011



The chart below shows the appeal and revocation rates as a percentage of all matters determined by Arbitrators. The significant decrease is supportive of a general increase in the quality and durability of arbitral decisions.

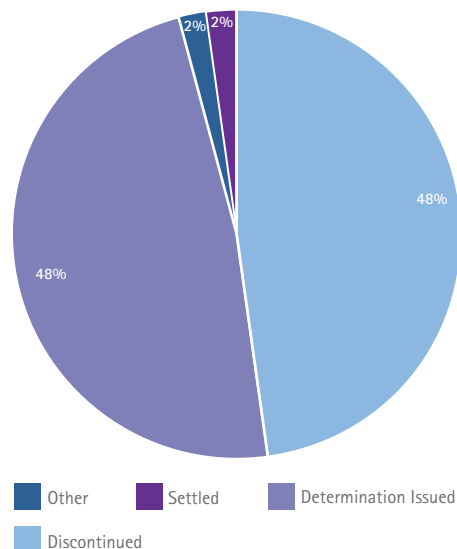
Arbitral Appeal Rate & Revocation Rate 2010 & 2011



Costs Assessments

During 2011, there were 95 costs assessment determinations issued, representing 48 per cent of all the Applications for Costs Assessment registered in the Commission. A further 48 per cent of applications were discontinued or withdrawn.

Cost Assessment Outcomes



NB: 'Other' includes matters that are rejected, recommenced or struck out.

Key Performance Indicators

During 2011, the Commission continued to monitor its performance against a series of key performance indicators (KPIs) first developed in 2008. The KPIs are intended to track the Commission's progress in the delivery of a number of our statutory objectives, including timeliness and durability of decisions:

KEY PERFORMANCE INDICATORS	
Timeliness	Target (if applicable)
% of Dispute Applications resolved within:	
→ 3 months	45% (excluding appeals) 40% (including appeals)
→ 6 months	85% (excluding appeals) 80% (including appeals)
→ 9 months	95% (excluding appeals) 94% (including appeals)
→ 12 months	99% (excluding appeals) 98% (including appeals)
Average days to resolution for Dispute Applications with no appeal	105
Average days to resolution of Arbitral Appeals	112
Average days to resolution of Medical Appeals	100
% of Expedited Assessment Applications resolved within 28 days	90%

The graphs that appear in the following section provide data that is benchmarked against the relevant KPI.

Timeliness

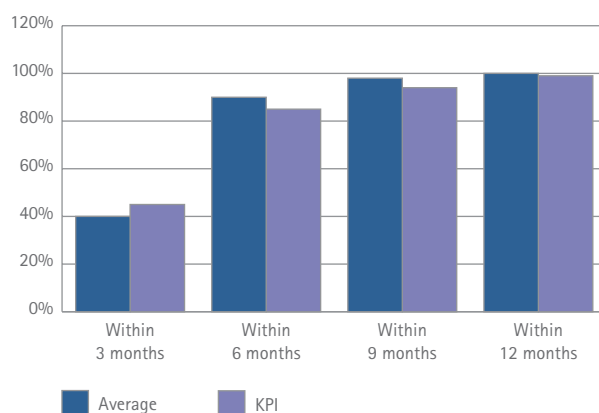
The Commission has developed a series of KPIs designed to monitor our effectiveness and efficiency in finalising dispute applications, both including and excluding appeal matters.

The Commission has set KPIs for the average number of days required to finalise applications, being 105 days for an ARD, 112 days for an arbitral appeal and 100 days for a medical appeal.

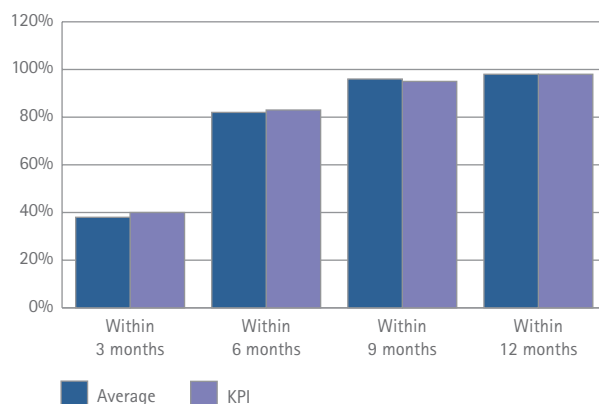
In most cases, the Commission was close to meeting or exceeding its KPIs during 2011, finalising approximately 41 per cent of all ARD applications (excluding appeals) in three months or less, with a total of 90 per cent being finalised within six months.

Fewer than one per cent of matters remain open for a period in excess of 12 months.

Time Taken to Finalise ARD Applications – Excluding Appeals

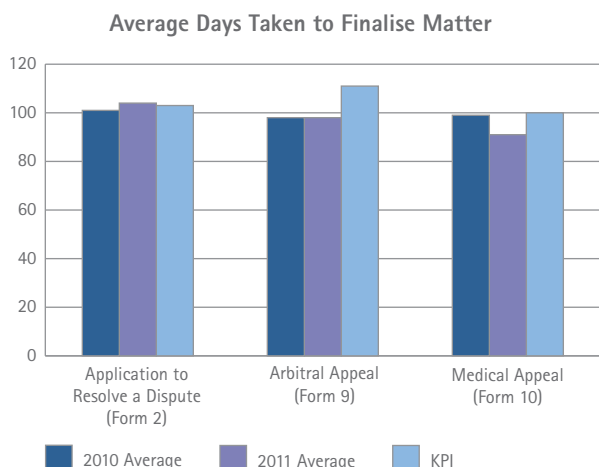


Time Taken to Finalise ARD Applications – Including Appeals



The actual average number of days achieved during the reporting year were 106 for an ARD, 99 for an arbitral appeal and 93 for a medical appeal, indicating the Commission met or exceeded its timeliness benchmarks.

The Commission has established a key performance indicator for arbitral appeal and Presidential determination, measuring the time from the date of filing to disposal of the application. The target set was 112 days and the Presidential Unit achieved a yearly average timeliness of 99 days. The timetable for the filing and serving of submissions generally occupied about 80 days of the target period.



Judicial Review of Registrar and Medical Appeal Panel Decisions

Parties who are aggrieved by decisions of the Registrar or Medical Appeal Panels may seek review of these decisions in the Supreme Court, pursuant to the *Supreme Court Act 1970*.

Applications

In 2011, the Supreme Court registered five new judicial review applications against decisions of the Registrar and Medical Appeal Panels, equal to the number of lodgments in 2010. This represents a judicial review rate of fewer than one per cent of all decisions made.

Notably, the applications were made against the decisions of only Medical Appeal Panels.

Decision-maker	Number of Applications Lodged
Medical Appeal Panel	5
Registrar	0
Medical Appeal Panel and Registrar	0
Total	5

There was one appeal lodged in the Court of Appeal against the decision of a single Judge of the Supreme Court relating to a decision made in respect of medical assessments.

Additionally, the High Court of Australia registered one Application for Special Leave to Appeal in relation to a decision of a Medical Appeal Panel already judicially reviewed and appealed. On 7 October 2011, the High Court heard the Special Leave to Appeal application of the worker in the matter of *Lukacevic v Coates Hire Pty Ltd* on the grounds that:

- the majority of the Court of Appeal erred in finding that the Appeal Panel's refusal to receive the worker's statement tendered in support of the medical appeal was not unreasonable, irrational or illogical;
- alternatively, the worker pursues the leave to appeal on the basis that the Court of Appeal erred in failing to find that the Appeal Panel failed to exercise its discretion, erred in law, asked the wrong question, and/or denied the worker procedural fairness, in refusing to admit the worker's statement for reasons that the Appeal Panel gave.

The High Court rejected the application with costs, determining that the actual decision of the majority of the Court of Appeal was correct.

Outcomes

In 2011, the Supreme Court and the Court of Appeal handed down a total of seven decisions in matters relating to decisions made by Medical Appeal Panels. A total of five judicial review and appeal applications were either discontinued or settled in both Courts.

Of all the judgments, four were judicial review decisions of the Supreme Court (two dismissed, two upheld) and three were judgments handed down by the Court of Appeal (three dismissed, zero upheld).

The High Court also refused to grant special leave to appeal in one application.

Decision-Maker	Dismissed	Upheld	Discontinued/ Settled	Special Leave to Appeal	Appeal time lapsed	Total
Medical Appeal Panel	5	2	5	1	1	14
Registrar	0	0	0	0	0	0
Medical Appeal Panel and Registrar	0	0	0	0	0	0
Total	5	2	5	1	1	14

Appeals to the Court of Appeal from Presidential Decisions

Appeals from Presidential decisions on points of law are made to the Court of Appeal.

In 2011, the Court of Appeal determined six appeals from Presidential decisions. One further appeal was remitted for re-determination by consent of the parties. The appeals that proceeded were determined as follows:

- 4 – appeal dismissed;
- 1 – appeal upheld and re-determined by the Court of Appeal, and
- 1 – appeal upheld and matter remitted to the WCC for rehearing.

In 2011, the appeal rate from Presidential decisions to the Court of Appeal was 8.1 per cent and the revocation rate of appealed Presidential decisions by the Court of Appeal was 33 per cent. The revocation rate of appealable decisions was three per cent.

THE STRATEGIC PLAN 2011-2014



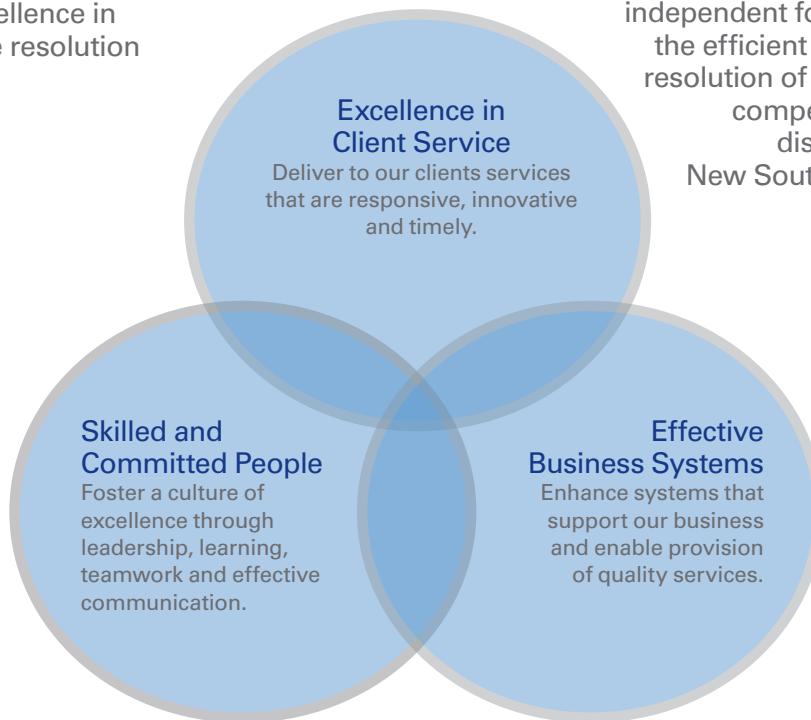
OUR VISION

To be recognised for excellence in dispute resolution

WORKERS
COMPENSATION
COMMISSION

OUR MISSION

To provide a fair and independent forum for the efficient and just resolution of workers compensation disputes in New South Wales



OUR VALUES

Fairness | Independence | Accessibility | Respect | Professionalism | Teamwork



The Planning Process

In June 2011, the Commission developed and finalised a three-year Strategic Plan. The plan was based upon a broad range of information gathered through a variety of channels, including consultation with members, staff and service partners; review of organisational data; and results from the client survey. The plan was reviewed in late 2011 to ensure that it adequately incorporated recommendations emerging from the organisational evaluation (see below).

The three-year Strategic Plan is published on the Commission's website as well as in the Annual Review. It informs the development of our annual Corporate Plan, Business Unit Plans and individual development plans. The three focus areas in the 2011–2014 Plan are: Excellence in Client Service, Skilled and Committed People, and Effective Business Systems.

Achievements under the Corporate Plan

1. Excellence in Client Services

Plan and Develop Education Programs for Stakeholders: Solicitors and Insurers

Injury Management Seminars Program

The Injury Management Seminars Program (IMSP) was established in May 2011. It is a collaborative initiative of the workers compensation insurance industry in New South Wales and is piloted under the stewardship of WorkCover NSW.

IMSP aims to support the professional development of workers compensation case managers by providing a regular program of practical seminars specifically targeting frontline case managers from all insurer types, including scheme agents, self insurers and specialised insurers.

As part of this program, the Commission's Legal and Medical Services Branch presented eight seminars (six in Sydney and two in Newcastle) in October 2011. The presentation was titled "Practical and Legal Considerations for Preparing Disputed Liability Notices" and provided a particular focus on s 74 notices.

The seminars also included an analysis and overview of the requirements of the workers compensation legislation, followed by group exercises aimed at developing skills and techniques in determining liability for claims, and identifying the relevant issues and reasons for disputing liability. Participants were also provided with a Discussion Paper, PowerPoint handouts and samples of dispute notices relevant to each of the case study exercises.

A total of 189 claims personnel attended the seminars. The feedback was extremely positive, earmarking the Commission's continued and active participation in future professional development initiatives for insurers.

Medical Appeal Panel Bulletin

In 2011, the Legal and Medical Support Unit introduced, published and distributed the new Medical Appeal Panel Bulletin, which provides feedback from members of Medical Appeal Panels to Approved Medical Specialists on how errors in medical assessments are addressed on medical appeals. The publication, edited by the Manager Legal and Medical Support Unit and Senior Approved Medical Specialists, also provides discussions and analyses of various cases of interest in relation to medical assessments and medical appeals. The bulletin is published on the Commission's intranet and extranet websites.

Arbitrator Practice Manual

In 2011, the Legal and Medical Services Branch issued three updates to the Arbitrator Practice Manual. Each update was accompanied by a summary of new content and the issues relevant to Arbitrators and service partners, members of the Commission, and staff.

On Review

Updates to 'On Review' were also maintained in 2011, with additions to the list of relevant and significant judicial review and appeal decisions of the Supreme Court and the Court of Appeal in relation to medical assessments, medical appeals and administrative decision-making functions of the Registrar.

On Appeal

In 2011, the Presidential Unit issued the 'On Appeal' bulletin to Arbitrators monthly. Each issue included summaries of determinations issued by the Presidential members in the preceding month and a brief overview of relevant Court of Appeal decisions. The bulletin is published on the Commission's intranet website and now on the extranet website for the assistance of the legal profession and other stakeholders.

Continuing Legal Education Presentations

In addition to members of the Commission, the President, the Registrar and the Deputy Registrars, qualified staff of the Commission have also presented in various commercial and accredited forums and seminars in 2011, both within and outside the Commission.

Post-implementation Evaluation of Organisational Changes

Following an organisational review conducted in 2008, the Commission evaluated two key recommendations relating to:

- the model of engagement of Arbitrators; and
- the internal structure of the Commission.

The review recommended the transition from a large group of contracted Arbitrators to a smaller pool of full-time, or substantially full-time, Arbitrators supported by sessional Arbitrators to cover rural locations and address any peaks in metropolitan caseload.

The shift to a smaller group of in-house Arbitrators commenced in July 2010.

The review also recommended the implementation of an internal restructure to deliver on a range of key objectives, including:

- Increasing the flexibility of task allocation within, and the level of collaboration between, dispute management and registry functions;
- Centralising the role of data analysis and reporting;
- Incorporating business support functions within a broader Business Support unit;
- Reducing the number of direct reports to the Registrar, and
- Providing enhanced career paths for staff.

During 2011, the Commission retained PricewaterhouseCoopers (PwC) to undertake an evaluation of the effectiveness of the recent reforms affecting the Commission. In particular, PwC examined the changes to arbitral services and the effectiveness of the internal structural changes.

In conducting the evaluation, PwC examined a broad range of data and information relating to the Commission's dispute resolution processes. A number of interviews and focus groups were also conducted to seek the views and input from Commission management, staff, Arbitrators, clients and other stakeholders. The final report was received by the Commission in September 2011. A copy of the report is available on the Commission's website.

PwC's report includes a range of positive findings about the success of the changes, including:

- The internal restructure was effective overall;
- The Commission has the right capability to deliver good client service;
- Arbitral decisions have become more durable and the resolution of matters more effective, with a substantial reduction in both the number of appeals and revocations;
- Consistency of outcomes is relatively high;
- External stakeholders are more satisfied with the Commission's services; and
- Average time to resolve matters has improved, with a small sacrifice in timeliness between the three and six month bands.

The report also made a number of recommendations for future action, including:

- recruitment of additional Arbitrators to address emerging workload and timeliness issues;
- modifications to some conference rooms in 1 Oxford Street to better accommodate proceedings; and
- development of a clear communication framework within the Commission.

The findings and recommendations were considered in refining the Commission's Strategic and Corporate Plans.

Client Survey

During 2011, the Commission engaged Newfocus consultants to undertake a client survey. Newfocus previously assisted the Commission in undertaking the 2008 client survey. The objectives of the survey were to:

- Identify the Commission's strengths and opportunities for service improvements;
- Understand user expectations and experiences regarding the service provided by the Commission;
- Measure satisfaction with a range of services provided by the Commission, including registry services, medical assessments, arbitral services, mediations and appeals; and
- Get feedback on information provision, sources of communication, and access and equity issues.

The report includes many findings across a broad range of areas, including improvements such as:

- An increase in the level of understanding of the Commission's role and responsibilities compared to the 2008 survey;
- 80 per cent of legal representatives satisfied or very satisfied with Commission's services (compared to 54 per cent in 2008);
- 71 per cent of workers satisfied or very satisfied (compared to 70 per cent in 2008);
- 43 per cent of insurers satisfied or very satisfied (compared to 39 per cent in 2008); and
- 35 per cent of employers satisfied or very satisfied (equal to 2008 levels).

There has been a significant increase in satisfaction levels relating to the dispute lodgment process since 2008. Legal representatives' overall satisfaction with the dispute lodgment process has increased from 56 per cent in 2008 to 74 per cent in 2011.

Three-quarters of legal representatives were satisfied or very satisfied with Arbitrators at teleconference (74 per cent). Overall satisfaction with Arbitrators at the conciliation/arbitration stage also increased from 53 per cent in 2008 to 82 per cent in 2011. Significant improvements were found in the following areas:

- explaining what was going to happen;
- understanding issues in dispute;
- providing adequate time for case to be heard;
- ensuring all parties understand what was happening;
- clearly explaining the outcome and what will happen next;
- attempting to resolve the dispute in the conciliation phase ;
- providing a fair and impartial decision in the arbitration process; and
- understanding workers compensation law.

The majority of injured workers reported satisfaction with the Commission's Approved Medical Specialists, with 66 per cent either satisfied or very satisfied (up from 56 per cent in 2008).

Based on the research, worker satisfaction with medical assessment is driven by:

- medical specialists being perceived as fair and objective; and
- medical specialists displaying politeness and professionalism.

Overall employer satisfaction ratings have remained largely on par with 2008 results at 35 per cent. However, results indicated the following improvements in satisfaction:

- Showing professionalism (67 per cent, up from 43 per cent in 2008).
- Being accessible (47 per cent, up from 32 per cent in 2008).
- Dealing with disputes in a timely manner (69 per cent, up from 59 per cent in 2008).
- Keeping parties informed of progress in dispute (65 per cent, up from 56 per cent in 2008).
- Providing communications that are easy to understand (75 per cent, up from 51 per cent in 2008).

Insurer satisfaction improved from 39 per cent in 2008 to 43 per cent in 2011. Dissatisfaction has also decreased, with 22 per cent dissatisfied in 2011 compared to 28 per cent in 2008. The report identified a number of opportunities for improvement, such as more effective information provision and communication with insurers and employers, as well as issues around regional access for medical assessments and conciliations/arbitrations. The report will help inform organisational initiatives and activities over the next three years.

2. Skilled and Committed People

Review, Recognition and Development Program

The Review, Recognition and Development (RRD) program was developed to improve performance by providing a clear basis for developing individual capabilities, reviewing performance, determining training and skills development needs, and recognising achievements.

After discussion with staff, management and unions, the Review, Recognition and Development Policy and Guidelines were finalised in May 2011 and the online tool was launched in August 2011.

Staff Development Activities

The Commission continued to sponsor staff undertaking formal studies as part of their professional development. Managers and supervisors were provided the opportunity to participate in the Diploma of Government as part of their Leadership Development Program and two staff members commenced the Diploma in Project Management. In 2011, five completed the Diploma of Government, six completed the Certificate III in Government, and eight completed Certificate IV in Government.

In 2011, staff from the Legal and Medical Services Unit undertook intensive workshops in commercial mediation, with the view to enhancing skills and capabilities in addressing the Commission's requirement to provide effective conciliation and mediation procedures for users of the scheme.

Arbitrator Professional Development Activities

Annual Arbitrator Conference

The 2011 Annual Arbitrator Conference provided an opportunity for discussion on various topics, including an overview of recent Presidential and Court of Appeal decisions, techniques for managing disputes with respect to s 11A of the 1987 Act, neurobiology and judicial decision-making, and observations of peer reviews and conciliation techniques.

Professional Development Committee

To address the specific development needs of Arbitrators, the Commission has also established the Professional Development Committee, with the objective of providing an advisory group through which professional development activities can be identified, discussed and implemented.

The Committee is responsible for providing input and advice in respect of content development, delivery methods and identification of high-calibre presenters for the Arbitrator Professional Development Conference and other regular forums.

Core members of the Committee include the Registrar as Chair, the Deputy Registrar Legal and Medical Services, the Manager Legal and Medical Support Unit, all Senior Arbitrators, and Arbitrators Craig Tanner and William Dalley.

Peer Review

In 2011, Arbitrators commenced peer review training for the purpose of assisting the peer reviewers to understand the process from both theoretical and applied perspectives, to understand the significance of self-awareness as an element for effective peer review, and to apply these understandings in peer review interviews.

Mediator Professional Development Activities

Mediator Forums

The Legal and Medical Support Unit also held Mediator Forums throughout 2011, focusing on topics that included "The Importance of the Opening Statement" and "Impressions of Mediation in the Workers Compensation Commission".

Approved Medical Specialist Professional Development Activities

AMS Practice Manual

The success and value of the Arbitrator Practice Manual provided the impetus for the Commission to prepare, develop and publish the AMS Practice Manual, designed to address the needs and requirements of Approved Medical Specialists in relation to various aspects of the workers compensation scheme in New South Wales.

In 2011, the Legal and Medical Services Branch commenced the drafting and preparation of the AMS Practice Manual, with the objective of providing a comprehensive resource material that deals with the roles and functions of Approved Medical Specialists in the Commission, the processes and procedures in relation to medical assessments and medical appeals, and significant developments in the law impacting on the Commission's roles, functions and objectives in resolving medical disputes.

The resource is being driven by a steering committee comprised of Senior Approved Medical Specialists, the President, the Registrar, the Deputy Registrar Legal and Medical Services and members of the Commission.

AMS Annual Conference

The AMS Annual Conference was held in mid-2011, with keynote speakers and presenters discussing various topics, including the role of the Registrar as a gatekeeper in medical appeals and the disease provisions in relation to deductions for pre-existing condition.

The Approved Medical Specialists in attendance also had the benefit of a more interactive conference during the well-received presentations on "Cross Cultural Issues Today – The Culturally Competent Professional" and "Eliciting Information from People with Communication Difficulties", both beneficial to the requirements of Approved Medical Specialists for dealing with aggrieved and injured workers.

Continuing Medical Education Requirements

In 2011, the Commission has obtained approval from relevant medical and professional colleges with which Approved Medical Specialists are affiliated to award the service partners accreditation points for attending professional and continuing medical education forums and conferences provided by the Commission.

The move ensures the significance of maintaining the high-quality content of the forums and conferences held by the Commission among Approved Medical Specialists and other medical practitioners within the workers compensation scheme.

Health & Safety Committee Report

The Commission continues to have a proactive Health and Safety Committee. The Committee systematically manages health and safety issues to ensure that the workplace is, as far as practicable, safe and without risks to the health of members, staff and visitors to the Commission.

During 2011, the Health and Safety Committee members were:

Abu Sufian, Chairperson

Karen Carpenter, Secretary

Memory McIntosh, Staff Representative

Emma Lethbridge-Gill, Staff Representative

Maria Manolopoulos, Staff Representative

John Schembri, Staff Representative

Rodney Parsons, Management Representative

Mary Walsh, Observer

The Health and Safety Committee continues to work in a cooperative relationship with the Commission's executive to ensure a safe work environment. In 2011, the Committee met regularly to discuss relevant issues. The Committee also monitors Injuries and Hazard Reports and is pleased to report only minor incidents during 2011.

The Committee conducted four inspections of the Commission's premises during the year. Following the inspections, the Committee prepared reports that identified potential hazards and maintenance requirements.

In 2011, the Health and Safety Committee:

- Actively participated in identifying risks and hazards in the workplace;
- Undertook training in relation to the new legislation, in preparation for its commencement on 1 January 2012;
- Arranged ergonomic assessments of workstations and equipment;

- Reviewed hazard and accident reports and made recommendations to the Commission's executive for appropriate remedial action;
- Undertook regular workplace inspections and ensured that all defects within the workplace were promptly remedied; and
- Communicated with staff through an electronic newsletter, posters, e-mails, and a presentation at the quarterly staff meeting.

3. Effective Business Systems

Business Continuity Plan

The Commission's structure and operations have undergone significant change over recent years. A strategic review of the Commission's entire Risk Management Framework is being carried out to reflect the current context within which the Commission now operates.

As part of the review, the Commission has reconsidered its approach to business continuity and crisis management. A holistic management approach is being adopted that identifies key business processes and potential threats to business continuity. It provides a framework for building resilience and the capability for an effective response to protect all stakeholders.

A new Business Continuity Plan (BCP) and Crisis Management Plan (CMP) have been developed and successfully tested in a simulation exercise, with the assistance of an independent observer. The exercise proved worthwhile in terms of helping the Crisis Management Team understand how a crisis evolves and how they might respond if involved in a real crisis.

Commence Redesign of Commission Website, Intranet and Extranet

In late 2011, the Commission engaged the services of a website development company to design and implement a new internet and intranet site, combining the current three sites. The new platform, utilising SharePoint 2010 technology, is due for completion in mid-2012.

The new sites will have an updated look and feel, improved navigation, enhanced search facilities and revised content.

Service Arrangements with CASD

Section 374(4) of the *Workplace Injury Management and Workers Compensation Act 1998* specifies that the WorkCover Authority will provide facilities and staff for the Commission's operations. Since commencement in 2002, the Commission's corporate services have been provided by the WorkCover Authority. This includes a suite of services incorporating human resources, finance, information technology and site services. Until 2011, the arrangements were reflected in a Service Partnership agreement between the Commission and the WorkCover Authority.

In June 2009, the then Premier announced the creation of 13 principal agencies, including the creation of the Compensation Authorities Staffing Division (CASD). One of the primary objectives was to consolidate service delivery across corporate services in human resources, finance and information technology. As a result of that process, CASD now comprises the following agencies:

- Workers' Compensation Dust Diseases Board;
- Lifetime Care and Support Authority;
- Motor Accidents Authority;
- WorkCover Authority; and
- The NSW Sporting Injuries Committee.

While the Workers Compensation Commission is not formally part of CASD, in all material respects we form part of the cluster and receive corporate services under a new CASD Shared Services Service Agreement. There is a high level of cooperation and collaboration between the Commission and other agencies within the cluster.

Review of Organisational Committees and Forums

One of the identified priorities of 2011/2012 was to review and consolidate organisational committees and forums. In late 2011, a discussion paper was developed canvassing a range of options and recommending a number of changes to existing committees and forums and the creation of several new forums. The discussion paper also recommended the strengthening of existing governance structures through the creation of written terms of reference and the formalising of secretariat support services and record-keeping. The changes will be further developed and implemented during the first half of 2012.





EDUCATION AND COLLABORATION

Inter-Jurisdictional Meeting

Each year in June, the Australasian Institute of Judicial Administration (AIJA) holds an annual Tribunals Conference that is well-attended by a range of decision-makers and staff from State, Territory and Commonwealth tribunals. Several years ago, it was agreed that, prior to the commencement of the Conference, an inter-jurisdictional meeting would be convened to promote information-sharing and collaboration across the various tribunals managing workers compensation disputes.

In 2011, the conference was held in Melbourne. By agreement, the Commission took responsibility for organising the meeting, with President Judge Keating as Chair.

Issues discussed included:

- legislative changes;
- medical decision-making;
- member recruitment; and
- professional development and performance management.

The 2012 meeting is scheduled to be held in Sydney.

Roadshows

During 2011, the Commission held a number of roadshow seminars as a means of providing free information regarding the Commission's operations and recent changes to workers compensation legislation, rules, regulations and their impact on stakeholders.

Nine seminars were conducted in February and March 2011, in the following locations: Albury, Newcastle, Orange, Penrith, Port Macquarie, Sydney CBD, Tamworth, Tweed Heads and Wollongong.

Almost 500 participants attended the seminars, with the audience comprised mainly of legal practitioners (56 per cent) and a combination of employers, insurers and self-insurers (31.7 per cent). More than 90 per cent of participants who completed a post-seminar evaluation indicated that they were satisfied or very satisfied with the seminars. In future, the Commission plans to run roadshows on a bi-annual basis.

Council of Australasian Tribunals

The Council of Australasian Tribunals (COAT) is a peak body that facilitates liaison and discussion between tribunals throughout Australia and New Zealand. It supports the development of best practice models and model procedural rules, standards of behaviour and conduct for members, and increased capacity for training and support for members.

During 2011, members and staff of the Commission participated in various activities organised by COAT, including the annual conference organised by the NSW Chapter in May 2011, the national annual general meeting held in Melbourne in June, and the Whitmore Lecture delivered in September in Sydney. The Registrar has been a member of the Executive Committee of the NSW Chapter for several years. The President was elected as a member of the Executive Committee at the Annual General Meeting in September 2011.

Law Society's Government and Administrative

Law Accreditation Working Group

During 2009, the Law Society of NSW announced that it would be developing a new area of accreditation in Government and Administrative Law.

In order to develop this new area, the Law Society established a working party which consists of knowledgeable and experienced practitioners currently working in the area, both within the public and private sectors. Accreditation was offered for the first time in 2011. During that time, the Registrar continued in her role as the Chair of the Government and Administrative Law Advisory Committee.

Injury Management Seminars Program Establishment Project

Stakeholder Reference Group

Rod Parsons, Deputy Registrar, Legal and Medical Services, is a member of the Stakeholder Reference Group for the Injury Management Seminars Program. The program was established in May 2011 under the stewardship of WorkCover NSW, with support from stakeholders across the workers compensation insurance industry. As a whole-of-industry initiative, it aims to support the professional development of workers compensation case managers in NSW by providing a regular program of practical and interesting seminars specifically designed for case managers.

A series of six seminars was held in July to December, with the Commission facilitating and presenting the fifth seminar on the topic of 'Practical and Legal Considerations When Preparing Dispute Liability Notices'. Further seminars are scheduled from February to April 2012.

Law Society Injury Compensation Committee

In 2011, Penelope Fleming, Research Associate to the Deputy Presidents, was a member of the Law Society Injury Compensation Committee, which is a committee of the Law Society Council.

The Committee is a source of expert advice and assistance to the Council, the Law Society and the legal profession on developments affecting the law and legal practice in the area of personal injury compensation.

The Committee members are volunteers and are representative of a broad range of the Law Society's constituent groups who have a balance of skills and knowledge in the focus area of law.

The activities of the Committee in 2011 focused on many issues, including:

- the proposed National Disability and Insurance Scheme;
- limitation periods for personal injury actions;
- the December 2010 amendments to the *Victims Support and Rehabilitation Act 1996*;
- the proposed pre-litigation protocols; and
- the development of a standardised Complying Agreement for use by all workers compensation insurers.

Stakeholder Presentations

As part of WorkCover's Injury Management Seminar Program, the Commission's Legal and Medical Services Branch presented eight sessions (six in Sydney and two in Newcastle) in October 2011. The sessions provided an overview of the requirements of the workers compensation legislation in relation to determining liability for claims. A total of 189 claims personnel attended the seminars.

Over the course of the reporting year, senior staff and Members participated in the following presentations:

His Honour Judge Greg Keating – President

23 May 2011 – WorkCover Board

27 October 2011 – Self-insurers Annual General Meeting

15 December – Law and Justice Committee on Tribunal Consolidation

Bill Roche – Deputy President

9 December 2011 – Arbitrators' Professional Development Day

Sian Leathem – Registrar

24 March 2011 – College of Law Government Solicitors' Forum

29 August 2011 – State Legal Conference

30 August 2011 – WorkCover Case Managers' Forum

15 September 2011 – UNSW Workers Compensation Seminar

14 October 2011 – University of Sydney Dispute Resolution Forum

15 December 2011 – Law and Justice Committee on Tribunal Consolidation

Rod Parsons – Deputy Registrar

25 February 2011 – Slater & Gordon

8 September 2011 – Law Partners Compensation Lawyers

Stakeholder and Client Publications

The Legal and Medical Support Unit introduced, published and distributed the Medical Appeal Panel Bulletin, which provides discussions and analyses of various cases of interest in relation to medical assessments and medical appeals. There were three updates to the Arbitrator Practice Manual issued, and updates to 'On Review' were also maintained in 2011.



DEVELOPMENTS IN THE LAW

NSW Court of Appeal Decision

New South Wales Police Force v Winter [2011] NSWCA 330

Workers Compensation – Appeal from Arbitrator to Presidential member – whether Arbitrator denied procedural fairness – content of obligations of procedural fairness in Workers Compensation Commission – where adverse credit finding made, whether party was given reasonable opportunity to answer the case against that party – rule in Browne v Dunn – where cross-examination terminated following objection by counsel of party claiming denial of procedural fairness – whether exchange of documentation before hearing gave party notice of the case that is put against that party – whether Arbitrator failed to give adequate reasons – task of Presidential member is to decide whether the Arbitrator has reached the correct view of the question that has been decided by the Arbitrator – allegation of “inadequacy of reasons” identifies decision as flawed because it has been arrived at without observing the legal requirements governing the manner in which the decision is arrived at, not because decision is in substance wrong – decision by Presidential member that Arbitrator has not given adequate reasons is not sufficient to justify Presidential member revoking or altering decision of Arbitrator unless Presidential member also decides that decision of Arbitrator is not the true and correct decision – nature of power to “review” – whether necessary for Presidential member to find error in decision of Arbitrator before setting aside – EVIDENCE – witnesses – cross-examination – rule in Browne v Dunn – where cross-examination terminated following objection by counsel of party claiming denial of procedural fairness

Giles JA, Campbell JA and Handley AJA
28 October 2011

Facts:

Mr Winter was a police officer who sought compensation for psychological injury that he alleged he had received in the course of his employment with the Police Force. He claimed weekly payments of compensation from 8 September 2008 onwards. He also claimed an award for medical and related expenses.

On 8 September 2008, Mr Winter saw Dr Gordon. The doctor's notes of that day stated "Still not happy at work. Trying to get out of patrol work. Stress has led to rash on body. Feels is being badly treated. Needs certificate stating too stressed to work". Dr Gordon's notes of 12 September 2008 recorded "Has spoken to union and they suggest he apply for PTSD for some of the episodes that have happened to him – violent episodes".

Mr Winter was cross-examined on these entries in Dr Gordon's notes. Following Mr Winter's counsel's objection, the Arbitrator stopped the cross-examination because the doctor's notes were in evidence and it was, in the Arbitrator's view, only a matter for submissions.

The Arbitrator held that Mr Winter had not suffered a psychological injury arising out of, or in the course of, his employment as defined in ss 4 and 11A(3) of the 1987 Act. The Arbitrator also found that there was insufficient evidence that Mr Winter had suffered an ongoing incapacity arising from any psychological injury he suffered at work on 8 September 2008. The Arbitrator made an award for the Police Force (see *Winter v NSW Police Force* [2010] NSWWC 211).

Mr Winter appealed to a Presidential member of the Commission. The Deputy President identified two grounds of appeal:

- a. the Arbitrator denied Mr Winter procedural fairness, and
- b. the Arbitrator failed to give adequate reasons.

The Deputy President held that:

- a. the Arbitrator denied Mr Winter procedural fairness by making an adverse credit finding on an issue that the worker did not have a reasonable opportunity to answer because she prematurely terminated cross-examination, and
- b. the Arbitrator failed to give adequate reasons as she failed to expose her reasoning on critical issues and did not analyse the medical evidence (see *Winter v NSW Police Force* [2010] NSWWC 121).

The Police Force sought leave to appeal the decision to the Court of Appeal.

Held: Leave to appeal granted – appeal upheld – orders of the Commission made on 16 November 2010 were set aside, order that the appeal to the Commission constituted by a Presidential member be dismissed and the decision of the Arbitrator confirmed.



Campbell JA (Giles JA and Handley AJA agreeing)

1. The issues on appeal were that the Presidential member erred in:
 - a. holding that there was a denial of procedural fairness in the decision of the Arbitrator;
 - b. holding that the Arbitrator's view about the credibility of Mr Winter was relevant to the Arbitrator's conclusion dismissing the employee's claim;
 - c. holding that the Arbitrator had failed to give adequate reasons for her decision, and
 - d. remitting the matter for re-determination where there was no error identified in, or disagreement with, the Arbitrator's conclusion that Mr Winter had failed to prove that he suffered incapacity as a result of the alleged workplace injury.

Was there a breach of procedural fairness?

2. The exchange of documents between the parties prior to the oral hearing was sufficient to notify Mr Winter that there was a live dispute about whether he suffered from a mental condition of sufficient seriousness to warrant classification as a "psychological injury". It was sufficient to notify him that there was a live issue about whether the reason for his absence from work was a psychological injury, rather than that he had undergone difficulties at work that he found disagreeable, even intolerable, but that had not precipitated a psychological injury. It would also have been sufficient to notify him that there was a live dispute about whether he was suffering any ongoing incapacity [82].
3. The exchange of documents before the hearing was sufficient to inform Mr Winter that the submission was to be made that, as at 8 September 2008, no diagnosis of PTSD had been made, the theory that he was suffering from PTSD had its origin in his union, or his statement incorrectly created the impression that Dr Gordon had diagnosed him with PTSD on 8 September 2008. At the hearing, the Police Force's counsel made it clear that he would make submissions attacking Mr Winter's credit. Mr Winter's counsel objected to the cross-examination, which provided the substantial reason why Mr Winter did not give his account of the complaints he made to Dr Gordon on 8 September 2008, of when and from what source the notion of him suffering from PTSD arose, and of why his statement indicated he had told Dr Gordon what had been happening at work and the symptoms he had been suffering [83].

4. The obligation to accord procedural fairness requires that a party be given notice of the case that is put against him or her, and a reasonable opportunity to put evidence and submissions before a tribunal concerning the case. Mr Winter had the opportunity, until his counsel took objection. As it was Mr Winter's counsel who took objection to the question being opened up, the present case was quite different to what it would have been if the Arbitrator, unprompted, had refused to permit the Police Force's counsel to explore the topics he wished to raise [84]. Therefore, the Deputy President was in error in holding there had been a denial of procedural fairness [85].

The Arbitrator's reasons

5. The task of a Presidential member in conducting a review under s 352(5) (before the amendments by the *Workers Compensation Legislation Amendment Act 2010*) was to decide whether the Arbitrator had reached the correct view and, if the Presidential member came to a different view, to resolve that question in the way that the Presidential member decided was correct. While there was a power to remit, that power was to be exercised bearing in mind the importance of the parties having available to them the skill and judgment of the Presidential member (see *Sapina v Coles Myer Ltd* [2009] NSWCA 71) [88].
6. An allegation of "inadequacy of reasons" identifies a decision as flawed because it was arrived at without observing the legal requirements governing the manner in which a decision was arrived at, not because the decision was wrong in substance [89].
7. Where the task of an appellant tribunal is to decide whether the primary decision-maker had given the right answer, the appellate tribunal does not carry out its task by asking whether the primary decision-maker had given adequate reasons. A decision by a Presidential member that an Arbitrator has not given adequate reasons was not sufficient to justify the Presidential member revoking or altering the decision of an Arbitrator unless the Presidential member also decided that the decision of the Arbitrator was not the true and correct decision [90]. The finding that the decision of the Arbitrator was not a true and correct decision required the Presidential member to consider the substance of the decision, not merely the procedure by which it had been arrived at [91].
8. As the allegation that there was a failure to accord procedural fairness failed, the argument concerning inadequacy of reasons was insufficient, by itself, to warrant a conclusion that the Arbitrator's decision was not the true and correct decision. If there had been some additional ground of appeal, relating to the substance of the Arbitrator's decision, that the Deputy President had upheld and on the basis of which he concluded that the Arbitrator's decision was not the true and correct decision, it might have been open to him to remit the matter. But without such an additional ground, inadequacy of reasons did not suffice [95].

Significant Presidential Member Appeal Decisions

Klemke v Grenfell Commodities Pty Ltd [2011] NSWWCCPD 27

Whether employment connected with New South Wales; s 9AA of the 1987 Act; meaning of "temporary arrangement"

Keating P
23 May 2011

Facts:

Mr Klemke commenced employment with Grenfell on or about 24 November 2009. Subject to a trial or probationary period of three weeks, he was employed to work as a site manager at the employer's premises at Kwinana Beach, Western Australia. He alleged that, during the trial or probationary period, on or about 10 December 2009, he injured his left ankle when he twisted it after stepping on a piece of timber.

Mr Klemke continued to work for Grenfell in Western Australia for the duration of the trial or probationary period, which ended on 16 December 2009, when he returned to New South Wales. He did not return to duties in Western Australia on 4 January 2010 (the date agreed between Mr Klemke and Grenfell), and has not worked since. He alleged he was incapacitated due to the injury on 10 December 2009.

Mr Klemke received voluntary payments of weekly compensation to 16 June 2010.

On 3 June 2010, Allianz issued notices under s 74 of the 1998 Act and s 54 of the 1987 Act denying liability for weekly payments after 17 June 2010 on the basis that:

- a. Mr Klemke's employment was not connected with New South Wales, and
- b. that he was not injured in the course of employment, and if he was, his employment was not a contributing factor to his injuries.

Mr Klemke lodged an application in the Commission on 24 August 2010, claiming weekly payments of compensation from 17 June 2010 and s 60 medical expenses.

Grenfell denied liability for the weekly payments and medical expenses, and disputed the quantum of any entitlement to weekly payments under ss 36 and 37.

Arbitrator's decision

The Arbitrator found that, pursuant to s 9AA(3)(a) of the 1987 Act, Mr Klemke was not entitled to recover compensation as a result of his alleged injury on 10 December 2009 because his employment was connected with Western Australia and not connected with New South Wales. The Arbitrator was not satisfied that the trial or probationary period was a "temporary arrangement" under s 9AA(6). The Arbitrator made an award for the respondent.

Appeal

Mr Klemke submitted on appeal that:

- a. the contract of employment was entered into in Grenfell, New South Wales, for the purpose of Mr Klemke attending Western Australia on a three-week temporary basis. It was therefore excluded, by the operation of s 9AA(6), for the purpose of determining where the worker "usually works";
- b. the parties intended that the three-week trial period was a "temporary arrangement";
- c. the three-week trial was a separate contract of employment to a permanent contract of employment that would be separately offered to the worker if both parties were in agreement. There was no agreement that Mr Klemke would work more than a three-week trial period;

- d. it was the intention of the parties that, if Mr Klemke did not complete the trial period or made an election not to work in Western Australia, he would return to New South Wales; however, he would not continue his employment with the employer, and
- e. the Commission should give effect to the words in the section and not import a narrow interpretation on the word "temporary" in s 9AA(6).

Held: Arbitrator's decision confirmed

1. Whether an arrangement is a "temporary arrangement" depends on the parties' intentions, which are ascertained by looking at the worker's work history and the terms of the contract. A short-term contract of less than six months that is not part of a longer or indefinite period of employment will not usually be a "temporary arrangement". (*Martin v R J Hibbens Pty Ltd* [2010] NSWWCPCD 83). The parties never intended that Mr Klemke would work anywhere other than in the State of Western Australia. The parties contemplated that, following completion of the trial or probationary period, if both parties were content to proceed with the contract, Mr Klemke would continue to work for Grenfell in Western Australia. There was no evidence that Mr Klemke's employment in Western Australia was a "temporary arrangement" [75]–[78].
2. Section 9AA(6) is intended to operate where a worker usually works under a contract of employment with an employer in one State and works under a "temporary arrangement" with that employer in another State for a period of not longer than six months. For s 9AA(6) to operate, any temporary arrangement contemplated by that provision must be seen as part of a longer or indefinite period of employment. The purpose of the section is to cover an employee who is normally based in one State and who, on a temporary basis, not longer than six months, is required to work in another State [79]–[80].
3. The evidence favoured the conclusion that Mr Klemke and Grenfell made a contract of indefinite duration that included a term that the first three weeks were to be a probationary period during which either party could terminate the agreement without penalty. That term did not make the contract a "temporary arrangement" within the meaning of s 9AA(6) such that a second contract would be entered into at the end of the probationary period. The contract commenced on 24 November 2009 and continued according to its original terms at the conclusion of the probationary period [83].

4. His Honour held that s 9AA(3)(a) identified Western Australia as the State where the worker usually worked. Relevant factors included:
 - a. he was employed at a managerial level, responsible for the day-to-day running of the site in Western Australia;
 - b. an annual salary had been agreed upon;
 - c. he received pro-rata holiday pay;
 - d. senior management travelled to Western Australia to familiarise Mr Klemke with the company's operations, and
 - e. he discussed with his wife moving there permanently and had been given time off work to inspect a residential property [84].
5. Mr Klemke's submission that the totality of s 9AA envisages that the worker is in permanent employment that is not temporary, and that to interpret s 9AA(6) to refer to workers in permanent employment but consigned to work in another State is to put too narrow a meaning on the provision, was rejected. The qualification concerning temporary arrangements in sub-s (6) is only relevant to a consideration of the "usually works" test in s 9AA(3)(a). The qualification is not relevant to the application of sub-ss (b) or (c) [88].
6. In the alternative, if the "usually works" test did not provide an answer to determine if the worker's employment was connected with the State, then, in the cascading sequences of test, it would be necessary to consider if the State in which the worker was "usually based" for the purposes of that employment under s 9AA(3)(b) identified a connection with the State. The "usually based" test identified Western Australia because the evidence unequivocally established that "for the purpose of" Mr Klemke's employment (whether temporary or long term) he was "usually based" in Western Australia [90]–[91].



***Qantas Airways Ltd v Strong* [2011] NSWCCPD 40**

Novel or complex question of law; application of s 69A of the 1987 Act; boilermaker's deafness; threshold requirements and additional allowances for severe tinnitus.

Keating P

3 August 2011

Facts:

Mr Strong was employed by Qantas as a baggage handler/ramp operator from 13 March 2002 to 16 July 2010. He alleged he was exposed to jet engine noise and the noise of heavy machinery used in loading and unloading aircraft, resulting in noise-induced hearing loss.

On 20 September 2010, Mr Strong made a claim for \$4,125 in respect of a three per cent whole person impairment relating to the alleged industrial deafness. His claim was supported by a report from Dr G Lucchese, an ear, nose and throat surgeon, who assessed a binaural hearing loss of 4.5 per cent. Dr Lucchese noted that Mr Strong suffered from severe tinnitus and added an additional two per cent, making the total compensable binaural hearing loss 6.5 per cent, which equated to three per cent whole person impairment.

Mr Strong was examined by Dr John Walker on behalf of Qantas on 16 November 2010. Dr Walker assessed a binaural hearing loss of 1.3 per cent.

On 31 December 2010, Qantas issued a s 74 notice under the 1998 Act denying the claim. Qantas relied on, among other things, s 69A of the 1987 Act on the basis that Mr Strong's total hearing loss due to industrial deafness was less than the six per cent threshold required by s 69A.

Mr Strong lodged an application in the Commission on 18 January 2011 in which he claimed \$4,125 in respect of a three per cent whole person impairment due to "binaural hearing loss". Qantas denied liability in its Reply filed on 28 January 2011.

Mr Strong was assessed by an AMS, Dr Kenneth Howison, on 14 March 2011. He recorded a 4.5 per cent binaural hearing loss. He also recorded symptoms of severe tinnitus and agreed with Dr Lucchese's assessment of a further two per cent additional loss, resulting in a 6.5 per cent binaural hearing loss, being a three per cent whole person impairment. A Medical Assessment Certificate was issued on 14 March 2011 recording those findings.

At a teleconference held by Senior Arbitrator Snell on 19 April 2011, both parties joined in an Application to Refer a Question of Law pursuant to s 351 of the 1998 Act. An Application was lodged in the Commission on 4 May 2011. Pursuant to Pt 16 r 16.1 of the 2011 Rules, the WorkCover Authority was joined as a respondent to the application.

Question 1:

Is it permissible in the application of s 69A of the 1987 Act to have regard to any allowance for severe tinnitus?

A. Yes.

Question 2:

Further or alternatively, does the correct application of s 69A of the 1987 Act require consideration only of a worker's binaural hearing loss without any addition of an allowance for severe tinnitus?

A. No.

Question 3:

Further or alternatively, whether severe tinnitus within the meaning of cl 9.11 of the *WorkCover Guides for the Evaluation of Permanent Impairment*, 3rd ed dated 6 February 2009 (the WorkCover Guides) constitutes hearing loss due to boilermaker's deafness within the meaning of s 69A(1) of the 1987 Act.

A. Not necessary to answer.

Leave to refer a question of law

1. The application was allowed, as the questions raised involved complex questions concerning the construction of s 69A of the 1987 Act and cl 9.11 of the *WorkCover Guides*, issued pursuant to s 376 of the 1998 Act, with respect to the assessment of the degree of permanent impairment arising from a work-related injury or condition occurring on or after 1 February 2009. The only decision on this issue was by Arbitrator Leigh Virtue in *Galea v Blacktown City Council* [2003] NSWCC 31 (*Galea*) determined on 2 May 2003. There are no decisions at Presidential level. Having regard to the amount of compensation in dispute, it is likely matters such as this would be excluded from an appeal under s 352 of the 1998 Act, as they are below the appeal threshold [28]–[29].

2. The employer submitted that complexity also arose from the fact that the threshold requirements in s 69A were introduced into the 1987 Act in 1995, whereas the *WorkCover Guides* introduced in 2002, for the first time, a component of compensation for severe tinnitus. The construction and interaction of these provisions had not been the subject of consideration by a Presidential member [31].
3. The worker's submission that there was no jurisdiction for the President to consider the matter as a question of law, due to the fact that an AMS had provided a certificate certifying the extent of the worker's impairment, was rejected. The certificate issued by the AMS is conclusively presumed to be correct as to the level of impairment, but does not equate to a determination of the dispute by the Commission (*Jopa Pty Ltd t/as Tricia's Clip-n-Snip v Edenden* [2004] NSWCCPD 50; 5 DDCR 321) [32].

Is it permissible in the application of s 69A of the 1987 Act to have regard to any allowance for severe tinnitus?

4. Section 69A of the 1987 Act was introduced by the *WorkCover Legislation Amendment Act 1995* – Act No 89 of 1995. Amendments were made to s 69A by the *WorkCover Legislation Amendment Act 1996* – Act No 120 of 1996. Section 69A was replaced in its entirety by the *Workers Compensation Legislation Amendment Act 2001* – Act 61 of 2001. However, all versions of s 69A required a loss of hearing due to boilermaker's deafness of six per cent or more before an entitlement under s 66 in respect of industrial deafness is established [61]–[62].
 5. Severe tinnitus was not a relevant factor or consideration when a worker's s 66 entitlement for industrial deafness was determined when the s 69A threshold was introduced. It only became relevant with the introduction of cl 9.11 of the *WorkCover Guides*, which regulates the determination of impairment entitlements in respect of injuries after 1 January 2002 [64]–[65].
 6. Section 33 of the *Interpretation Act 1987* is relevant in determining the construction of s 69A of the 1987 Act and cl 9.11 of the *WorkCover Guides*, and that section requires a purposive approach to interpreting statutory provisions [67].
 7. Qantas and WorkCover submitted that the determination of the question required a literal interpretation of s 69A, as the section did not expressly or impliedly authorise or permit regard to be had to tinnitus or severe tinnitus in the assessment of permanent impairment resulting from the loss of hearing due to boilermaker's deafness.
- That submission ignored the fact that the assessment of an entitlement to compensation for boilermaker's deafness is governed by the application not only of s 69A, but also by s 322 of the 1998 Act and by cl 9.11 of the *WorkCover Guides*. Section 322(1) provides that assessments for the purposes of the Workers Compensation Acts be made in accordance with the *WorkCover Guides* (in force when the assessment is made) issued for that purpose. The *WorkCover Guides* are specific and unambiguous, in that an allowance of up to five per cent may be added to the work-related binaural hearing impairment before the determination of the whole person impairment [69].
8. WorkCover has power to issue guidelines with respect to the assessment of the degree of permanent impairment pursuant to s 376 of the 1998 Act. WorkCover first issued Guidelines for the *Evaluation of Permanent Impairment in 2001*. These have been reviewed and updated and all versions made an allowance for severe tinnitus [70]–[71].
 9. Qantas also submitted that it was significant that s 69A(4), which provides several examples to illustrate the operation of s 69A(1), did not provide an example of an allowance for severe tinnitus in determining whether the threshold had been met. However, the three examples in that section are not an exhaustive list and are principally directed to the application of s 69A in a case of multiple hearing losses or for losses falling under the threshold [74].
 10. Qantas relied on the Minister's Second Reading Speech at [49] to argue that to allow a worker to utilise an allowance for tinnitus to satisfy the threshold would constitute a weakening or reduction of the s 69A(1) threshold. However, the Minister's remarks concerned the administrative costs associated with small claims, and did not provide any support for Qantas's submissions concerning the utilisation of an allowance for severe tinnitus in connection with the satisfaction of the threshold requirements [76]–[77].
 11. Statements as to legislative intention made in explanatory memoranda or by Ministers cannot overcome the need to carefully consider the words of the statute to ascertain its meaning. (In *Saeed v Minister for Immigration and Citizenship* [2010] HCA 23 at [31], the plurality approved the observations of Gummow J in *Wik Peoples v State of Queensland* (1996) 187 CLR 1; HCA 40). Even if Qantas's submission regarding the import of the Minister's remarks was accepted, it could not overcome the language of cl 9.11 [78]–[79].

12. Section 69A creates an entitlement to compensation for boilermaker's deafness although no compensation is payable unless the worker's total hearing loss is at least six per cent. The provision does not prescribe how the assessment is to be undertaken. The application of s 322 of the 1998 Act provides that the task is to be undertaken in accordance with the terms of the *WorkCover Guides*, which prescribe how the assessment is to be made [80].
13. The *WorkCover Guides* are expressed in clear and unambiguous terms. An allowance of up to five per cent may be added to the work-related binaural hearing impairment for severe tinnitus caused by a work-related injury, after presbycusis correction if applicable, and before determining the whole person impairment [82].
14. WorkCover submitted that tinnitus is a secondary symptom of binaural hearing impairment and does not stand alone as a compensable impairment in the absence of binaural hearing loss. It argued that it therefore should not be permissible to add any allowances for tinnitus to the noise-induced binaural hearing loss in order to aggregate the total losses to exceed the six per cent threshold.

It was held that whether the condition is characterised as a secondary symptom or not is irrelevant because tinnitus is recognised as a compensable condition under the *WorkCover Guides* and any additional allowance for tinnitus must be added to the assessed hearing impairment before an assessment of the whole person impairment is reached [84].

15. Since the decision in *Galea*, the *WorkCover Guides* have been reissued on two occasions. Had the legislature intended that any allowance for severe tinnitus was to be excluded for the purposes of satisfying the threshold in s 69A(1), it could have done so, but it has not [87].
16. Workers compensation legislation is beneficial legislation. Entitlements under beneficial legislation should not depend on "distinctions which are too nice" (*Articulate Restorations & Developments Pty Ltd v Crawford* (1994) 10 NSWCCR 751 at 765, per Mahoney JA). However, the principle that beneficial legislation should be given a liberal construction does not entitle a court to give it a construction that is unreasonable or unnatural (per McColl JA in *Amaca Pty Ltd v Cremer* [2006] NSWCA 164, citing *IW v City of Perth* [1997] HCA 30; 191 CLR 1 (at 11–12) per Brennan CJ and McHugh JJ).

If there was any ambiguity in the language used, then in the context of beneficial legislation, the ambiguity should favour the worker and the Acts should be construed beneficially (*Bull v The Attorney General for New South Wales* [1913] 17 CLR 370 at 384) [88]–[90].



Raulston v Toll Pty Ltd [2011] NSWCCPD 25

Failure to give adequate reasons; unsatisfactory pleadings; inappropriate use of the expression "nature and conditions" of employment; approach to appeals from decisions after 1 February 2011; s 352 of the 1998 Act

Roche DP

17 May 2011

Facts:

Mr Raulston worked for Toll as a truck driver from about 1997 driving a car carrier. He was required to load, unload and transport cars between Melbourne and Wagga Wagga. He alleged that he injured his neck in the course of or arising out of his employment with Toll. Because of the unsatisfactory pleadings, the exact nature of the claim was unclear.

Mr Raulston submitted a claim form on 6 November 2006, alleging he injured his neck and shoulder in the course of his employment on 30 October 2006 while pulling a winch bar to tighten a chain to secure a car. Following the incident, his doctor certified him unfit for two days because of a sprained right shoulder. A second certificate certified him fit for suitable duties from 4 November 2006 until 7 November 2006 because of a sprained right shoulder and neck pain. Mr Raulston returned to normal duties on 8 November 2007.

In the course of unloading his trailer at Melbourne on 17 September 2007, Mr Raulston was struck on the bridge of his nose by a car door. He continued working and returned to Wagga Wagga. Mr Raulston stated that, over the next few weeks, he had headaches, pain in his nose and difficulty breathing. He also had pain when he sneezed, which he did a lot more after the accident. He further stated that, in the weeks up to 20 November 2007, there had been a "build up" of pain in his neck and shoulders which increased over time with normal work and movement.

On 20 November 2007, while at home, Mr Raulston sneezed and felt extreme pain in the region of his neck and shoulders and under his armpits. He said he also felt a crack somewhere in his neck. The pain caused him to fall to the ground and he felt paralysed and remained on the ground for approximately 20 to 30 minutes.

Mr Raulston did not return to work on 21 November 2007. An MRI scan on 11 March 2008 showed a disc prolapse at C5/6. On 23 October 2008, Mr Raulston underwent a C5/6 discectomy and fusion.

Mr Raulston's Application alleged an injury due to the "nature and conditions" of employment and as a result of the incident on 17 September 2007. He claimed weekly compensation from 21 November 2007 to 1 March 2009, lump sum compensation in respect of a 25 per cent whole person impairment, and a general order for the payment of hospital and medical expenses.

Toll conceded Mr Raulston suffered an injury to his nose on 17 September 2007. It alleged that the sneezing episode at home on 20 November 2007 had not resulted in an injury arising out of or in the course of his employment and that employment had not been a substantial contributing factor to Mr Raulston's injuries.

The Arbitrator held that Mr Raulston had not established any connection between the earlier work injuries and the clear incapacity that followed immediately after the sneezing event and fall at home. He found the injury received on 17 September 2007 was a soft tissue injury to Mr Raulston's nose and face. The Arbitrator did not think there was any reliable evidence of any substantial injury having occurred in September 2007 or before that date.

Held: Arbitrator's determination revoked and the matter remitted to a different Arbitrator for re-determination

Issues on appeal

1. The issues on appeal were whether the Arbitrator erred in:
 - a. determining that Mr Raulston had not given any reliable evidence of any substantial injury having occurred in September 2007, nor before that date;
 - b. failing to give any, or any adequate, reasons as to the basis for his determination that there was inadequate reliable evidence of any substantial injury having occurred in September 2007, or before that date;
 - c. preferring the evidence of Dr Krishnan having regard to there being no evidence from Mr Raulston with respect to any history of hay fever, and
 - d. preferring the evidence of Drs Smith and Krishnan to that of Dr Evans without giving adequate reasons for doing so.

"Nature and conditions" of employment

2. The Commission has repeatedly held that the expression "nature and conditions" is meaningless and should not be used (*Toplis v Coles Group Ltd t/as Coles Logistics* [2009] NSWCCPD 70). Practitioners are directed to cease using the expression without properly explaining the nature of the claim and the cause of the injury. Pleadings must properly identify the cause of injury, the nature of injury, and whether it is alleged that the worker received a personal injury, under s 4(a) of the 1987 Act, or a disease injury under either s 4(b)(i) or s 4(b)(ii) [10].

Appeals from decisions after 1 February 2011 – the effect of s 352 of the 1998 Act

3. There are number of points to note about the new s 352:
 - a. an appeal from an Arbitrator to a Presidential member is no longer a "review" and is not a hearing *de novo*. It is an appeal limited to the determination of whether the decision appealed against was or was not affected by an error of fact, law or discretion, and to the correction of any such error;
 - b. save for interlocutory decisions, it is not necessary to seek leave to appeal;
 - c. leave to appeal interlocutory decisions may only be granted if the Commission is of the opinion that determining such an appeal is necessary or desirable for the proper and effective determination of the dispute;
 - d. fresh evidence or additional evidence or evidence in substitution for the evidence received in relation to a decision appealed against may not be given on an appeal except with leave. The Commission is not to grant leave unless satisfied that the evidence concerned was not available to the party, and could not reasonably have been obtained by the party, before the proceedings concerned, or that failure to grant leave would cause substantial injustice in the case;
 - e. the lodging of an appeal does not operate as a stay or otherwise affect the operation of a decision as to weekly payments of compensation. However, the appeal stays the operation of other orders pending the appeal determination, and
 - f. on appeal, the decision appealed against may be revoked and a new decision made in its place, or the matter may be remitted to an Arbitrator for determination in accordance with any decisions or directions of the Commission [17].
4. On appeal, the Commission will have regard to the principles stated by Barwick CJ in *Whiteley Muir & Zwanenberg Ltd v Kerr* (1966) 39 ALJR 505 at 506 (cited with approval by Brennan CJ, Toohey, McHugh, Gummow and Kirby JJ in *Zuvela v Cosmarnan Concrete Pty Ltd* [1996] HCA 30; 140 ALR 227):
 - a. an Arbitrator's finding on the primary facts may only be disturbed on appeal by a Presidential member if "other probabilities so outweigh that chosen by the [Arbitrator] that it can be said that his [or her] conclusion was wrong";
 - b. an Arbitrator may draw a particular inference from the primary facts and these will only be displaced if it is shown that the Arbitrator was wrong, and
 - c. an Arbitrator may be shown to be wrong by showing that material facts have been overlooked, or that he or she gave undue or too little weight in deciding the inference to be drawn, or that another inference is so preponderant that the Arbitrator's decision is wrong [19].
5. The appeal will be conducted on the transcript of the evidence presented at arbitration unless leave is given to tender fresh or additional evidence [22].
6. Parties will usually be bound by the presentation of their case at the arbitration and neither party will be permitted to raise new issues on appeal where those issues could have affected the outcome or course of the arbitration and been met with additional evidence in response: see *Coulton v Holcombe* [1986] HCA 33; 162 CLR 1 at 7; *University of Wollongong v Metwally (No 2)* [1985] HCA 28; 59 ALJR 481; *Water Board v Moustakas* [1988] HCA 12; 180 CLR 491; *Suttor v Gundowda* (1950) 81 CLR 418 at 438. This principle is subject to the Commission's power to allow (with leave) fresh evidence or additional evidence in s 352(6) of the 1998 Act [23].
7. What constitutes an appealable error of fact, law or discretion will be determined on a case-by-case basis (see *Fox v Percy* [2003] HCA 22; 214 CLR 118 at [22]–[31]) [25].
8. Credibility-based findings may be overturned if "incontrovertible facts or uncontested" evidence establish they were wrong (*Fox v Percy* at [28]). In rare cases, although the facts fall short of being "incontrovertible" such findings may be overturned if they are "glaringly improbable" or "contrary to compelling inferences" in the case (*Fox v Percy* at [29] citing *Brunskill v Sovereign Marine & General Insurance Co Ltd* [1985] HCA 61; 59 ALJR 842 at 844 and *Chambers v Jobling* (1986) 7 NSWLR 1 at 10 [26].

9. Challenges to an Arbitrator's exercise of discretion will be in accordance with the principles in *House v The King* [1936] HCA 40; 55 CLR 499 at 504–5 as articulated by Heydon JA (as his Honour then was) (Sheller JA and Studdert AJA agreeing) in *Micallef v ICI Australia Operations Pty Ltd* [2001] NSWCA 274 at [45]. To succeed with an appeal against an Arbitrator's exercise of discretion, the appellant must demonstrate that the Arbitrator:
 - a. made an error of legal principle;
 - b. made a material error of fact;
 - c. took into account some irrelevant matter;
 - d. failed to take into account, or gave insufficient weight to, some relevant matter, or
 - e. arrived at a result so unreasonable or unjust as to suggest that one of the foregoing categories of error had occurred, even though the error in question did not explicitly appear on the face of the reasoning [27].
10. A Presidential member will not overturn a discretionary decision because he or she "might have reached a different conclusion or because intuitive feelings suggest to them a different outcome in the particular case" (*The Queen v Taufahema* [2007] HCA 11; 234 ALR 1) [28].
11. A Presidential member will not disturb an award of compensation for pain and suffering, or a decision analogous to a decision involving the exercise of discretion as to be assimilated to a discretionary judgment, unless the Arbitrator has acted on a wrong principle of law or has misinterpreted the facts or made a wholly erroneous estimate of the damage suffered (*Moran v McMahon* (1985) 3 NSWLR 700 at 702E, 722G, 726F; *Wilson v Peisley* (1975) 7 ALR 571 at 585, and *Costa v The Public Trustee of NSW* [2008] NSWCA 223 at [105]) [29].
12. In relation to an error involving a departure from the rules of natural justice or procedural fairness, an appellant must show that the departure deprived him/her of the possibility of a successful outcome (*Stead v State Government Insurance Commission* (1986) 161 CLR 141 at 147) [30].

Failure to give adequate reasons

13. To succeed on this ground, it was necessary for the appellant to demonstrate not only that the reasons were inadequate, but that their inadequacy disclosed that the Arbitrator had failed to exercise his statutory duty to fairly and lawfully determine the application (*YG & GG v Minister for Community Services* [2002] NSWCA 247; *Absolon v NSW TAFE* [1999] NSWCA 311; *ADCO Constructions Pty Ltd v Ferguson* [2003] NSWSCPD 21) [44].
14. The Arbitrator did not explain why he did not think there was any reliable evidence of any "substantial injury" having occurred in September 2007 or before that date. If Mr Raulston's evidence had been accepted, it supported his claim. The Arbitrator did not say if he accepted or rejected Mr Raulston's evidence [51].
15. The statements by the Arbitrator that there was "no evidence of any significant period of incapacity flowing from the September incident" and that the clinical records did not disclose any treatment "in respect of the September accident" did not provide adequate reasons for the conclusion that there was "no reliable evidence of any substantial injury having occurred in September 2007 nor before that date". The statement that there was "no evidence of any significant period of incapacity flowing from the September incident" was incorrect, as Dr Evans provided evidence on the causation issue. Although the clinical records did not disclose treatment in relation to the September incident, the Arbitrator did not say what weight he placed on those notes, he merely observed that they were a factor to be considered [52].
16. The Arbitrator's finding that the only injury suffered on 17 September 2007 was to Mr Raulston's nose and face was inconsistent with the Arbitrator's comment that Mr Raulston's statement noted "some neck and shoulder symptoms" which were not substantial. Symptoms do not have to be "substantial" to constitute an injury or for an incapacity to result from them. The statement relating to the neck and shoulder symptoms implied, contrary to his statement that Mr Raulston only injured his nose and face, an acceptance of Mr Raulston's case that he had injured his neck on 17 September 2007 [53].
17. Although the Arbitrator concluded that Mr Raulston's incapacity and impairments resulted from the non-work incident on 20 November 2007, he did not properly explain how he reached that conclusion and did not properly deal with the issues or the parties' submissions. He did not say why he rejected the worker's submission that the incapacity was the inevitable result of the September 2007 injury [54].

18. An Arbitrator is required to engage with expert evidence and explain why one expert's evidence is preferred over that of another (*Sant v Tsoutsas* [2009] NSWCA 3 at [77]). The Arbitrator stated he preferred the opinions of Drs Smith and Krishnan to those of Dr Evans. Other than saying that Dr Evans was "far from definitive in his view", the Arbitrator erred in not giving reasons for preferring the other doctors' opinions [55].
19. The Arbitrator's reference to "earlier injuries" was (presumably) a reference to the injuries to Mr Raulston's neck and shoulder on 30 October 2006 and 23 March 2007. While it was open to conclude that those incidents did not render Mr Raulston "susceptible" to further injury by way of predisposition or vulnerability, that was not Mr Raulston's case. His case was that, based on the evidence from Dr Evans, one-fifth of his disability resulted from his duties as a truck driver, including the incidents on 30 October 2006 and 23 March 2007. The Arbitrator's only reference to those injuries was when he said none of the "prior injuries" appeared "to be significant to this claim", yet Dr Evans said they contributed to the impairment. The Arbitrator did not deal properly or fairly with the allegations about the "earlier injuries" [57].

***Hesami v Hong Australia Corporation Pty Ltd* [2011] NSWCCPD 14**

Compensation for gratuitous domestic assistance; s 60AA of the Workers Compensation Act 1987; whether compensation is payable for care provided before the establishment of a care plan; meaning of "in accordance with"; circumstances in which previously unnotified matters may be heard or otherwise dealt with by the Commission; ss 289A and 74 of the Workplace Injury Management and Workers Compensation Act 1998

Roche DP
11 March 2011

Facts:

On 5 December 2005, Mr Hesami sustained a serious back and shoulder injury in the course of his employment with Hong Australia Corporation Pty Ltd. He underwent back surgery on 22 March 2006, returned to work on light duties after surgery, and ceased work in July 2006. He did not return to work.

Mr Hesami was severely disabled because of his injuries and was unable to care for himself. His wife and brother-in-law provided gratuitous care to him and Mr Hesami claimed compensation for that domestic assistance under s 60AA of the 1987 Act.

He commenced proceedings in the Commission on two occasions seeking domestic assistance compensation and discontinued each application because the insurer had not prepared a "care plan" as required by s 60AA(1)(d).

The insurer finally prepared a care plan on 19 January 2010. Mr Hesami claimed \$226,498.20 for domestic assistance in a third application lodged with the Commission on 5 July 2010.

The insurer did not serve a s 74 notice until 9 July 2010. It disputed liability on the basis that Mr Hesami's wife and brother-in-law had not provided evidence that they had lost income or forgone employment as a result of providing assistance to Mr Hesami (s 60AA(3)).

The insurer filed a Reply on 16 July 2010 in which it relied on the issue in the late s 74 notice and alleged, as it had in the earlier proceedings, that assistance had to be provided "in accordance with a care plan".

The insurer settled the claim for gratuitous domestic assistance provided by Mr Hesami's brother-in-law from 18 July 2009.

At the start of the arbitration, counsel for Mr Hesami raised a "threshold point" as to whether, because of the late s 74 notice, the insurer had ever denied the claim. Counsel for the respondent submitted that it had been assumed that s 74 notices had been served and it had always been the situation that the claim for the cost of gratuitous domestic assistance was disputed. The Arbitrator did not rule on that point, but heard submissions on the substantive claim and reserved her decision.

With respect to the threshold point, the Arbitrator stated that it was in the interests of justice to "permit the dispute to be dealt with". She found that Mr Hesami had "not met the onus of establishing that his wife has foregone [sic] employment and lost income as a result of providing domestic assistance" and that the conditions of s 60AA and the Guidelines had not been met. She made an award for the respondent employer. Mr Hesami appealed.

The issues in dispute on appeal were whether:

- a. the Arbitrator erred in permitting the respondent employer to rely on the s 74 notice dated 9 July 2010;
- b. the Arbitrator erred in finding that Mr Hesami's wife had not established that she had lost income or forgone employment as a result of providing domestic assistance him, and
- c. the provider of the domestic assistance could recover compensation for gratuitous assistance provided before the preparation of a care plan.

In respect of the late s 74 notice, Mr Hesami submitted that:

- a. the Arbitrator only considered prejudice to Mr Hesami, but failed to consider the other matters in *Mateus v Zodune Pty Ltd t/as Tempo Cleaning Services* [2007] NSWCCPD 227; 6 DDCR 488;
- b. the insurer provided no explanation as to why it had not served a s 74 notice until 9 July 2010;
- c. in view of the history of the matter, Mr Hesami was entitled to see the real issue as the institution of a care plan, not the question of lost income or foregone employment, and
- d. the Arbitrator identified deficiencies in the evidence on the issue of whether his wife had lost income or foregone employment as a result of providing domestic assistance to him. That conclusion "flies in the face of her conclusion that there's no prejudice to the Applicant" (appeal hearing T9.28).

The respondent submitted that the insurer served the s 74 notice just a few days after the application was lodged in the Commission, Mr Hesami had about two months to deal with the issues raised, and the "delay of one week was not prejudicial".

In relation to the fact that there was no care plan prepared until January 2010, Mr Hesami submitted that the words in s 60AA should be given their ordinary meaning. The dictionary meaning of "in accordance" is "correspondence, agreement, conformity, harmony and consistency". He agreed that there could be no liability until a care plan was instituted, but once instituted, its terms simply serve to limit the quantum of the assistance that is compensable. So long as what has been provided is "in accordance, agreement, conformity, harmony, consistent with that plan" then, subject to any other statutory qualification, liability is made out. The section does not require that assistance be provided "pursuant to" a care plan.

The respondent submitted that a care plan had to be established by the insurer before assistance could be provided and there was no requirement to pay for gratuitous assistance until a care plan has been established.

Held: The Arbitrator's determination was revoked. The matter was remitted to a different Arbitrator to determine the only issue remaining in dispute, namely, whether Mr Hesami's wife had lost income or foregone employment to provide domestic assistance to him

Section 74 notice

1. The s 74 notice was several months out of time (see s 279 of the 1998 Act), not a few days as the respondent had submitted. The length of the delay and the lack of explanation for that delay strongly militated against allowing the insurer to rely on the late notice [31].
2. However, as the application had attached to it a considerable body of evidence that could only have been relevant if the insurer disputed the entitlement to compensation for gratuitous domestic assistance, it was difficult to see that Mr Hesami's legal advisers were taken by surprise by the issue in the s 74 notice [32].
3. At the teleconference on 9 August 2010, neither party took issue with the late notice. The main function of the teleconference is to deal with preliminary matters of this kind to ensure that the matter is ready to proceed to conciliation and arbitration. Neither party raised the issue of the late s 74 notice at the teleconference and that was unsatisfactory [33].
4. The Commission has a statutory duty to act according to equity, good conscience and the substantial merits of the case. Given the long history of the matter, the issues in the previous replies filed, the fact that the notice only raised one issue, and the nature of the evidence attached to the worker's application, the Arbitrator did not err in giving the insurer leave to rely on the notice [34].
5. However, in giving leave to rely on the notice in the course of her reserved decision, as opposed to at the hearing, and then finding that, because of deficiencies in the evidence, Mr Hesami had not met the onus of establishing that his wife had forgone employment and lost income as a result of providing domestic assistance, the Arbitrator deprived him of the opportunity of seeking to call oral evidence to address the alleged deficiencies in his case or seeking an adjournment to cure the defects [35].
6. The deficiencies in the evidence only became critical once the Arbitrator gave the insurer leave to rely on the late notice. Mr Hesami therefore suffered a significant prejudice and was deprived of the opportunity to fully meet the issue raised by the late reliance on the s 74 notice [36].

The care plan

7. In interpreting s 60AA, the following was considered:

- a. section 60AA must be construed having regard to its legal and historical context, and the text and structure of the Act: *Wilson v State Rail Authority of New South Wales* [2010] NSWCA 198 at [12];
- b. the workers compensation legislation is "beneficial legislation" [44];
- c. the principle that beneficial legislation should be given a liberal construction does not entitle a court to give it a construction that is unreasonable or unnatural (per McColl JA in *Amaca Pty Ltd v Cremer* [2006] NSWCA 164, citing *IW v City of Perth* [1997] HCA 30; 191 CLR 1 (at 11–12) per Brennan CJ and McHugh J) [44];
- d. section 60AA represents a significant extension of the benefits payable [under the 1987 Act] and it is appropriate that claimants should establish their entitlement in accordance with the legislation [45];
- e. the use of the conjunction "and" between each of the sub-sections in s 60AA(1) makes it clear that each of the requirements in the sub-sections must be satisfied before an employer is liable to meet the cost of domestic assistance [46];
- f. the intention of the section is that, provided certain conditions are met, employers are liable for the cost of domestic assistance that is reasonably necessary as a result of the injury [47];
- g. there is no logical reason why compensation can only be recovered for assistance provided after the preparation of the care plan. The need for and provision of domestic assistance will always occur before the insurer establishes the care plan. The position contended for by the employer would allow liability under s 60AA to be avoided altogether, or substantially reduced, by delaying in obtaining a care plan [48];
- h. domestic assistance is to be provided "in accordance with" a care plan but that does not mean that there is no liability for assistance provided before the creation of a care plan [49];
- i. "in accordance with" should be construed as meaning "in conformity with" or "consistently with": *Walker v Wilson* [1991] HCA 8; 99 ALR 1 (at 11) [50];

8. Regardless of when the domestic assistance was provided, if it was in conformity with or consistent with the care plan, then, provided the other conditions in s 60AA are satisfied, the claimant is entitled to succeed [51].
9. The cost of gratuitous domestic assistance is to be calculated in accordance with cl 7.4 of the Guidelines and *Kajic v Hawker De Havilland Aerospace Pty Ltd* [2009] NSWCCPD 136. The claim for \$226,498.20 was not consistent with the Guidelines or *Kajic* [55].
10. The conduct of this matter by both sides would not be a model to be followed in future claims of this type [56].

Significant Judicial Review Decision of the Court of Appeal

Vitaz v Westform (NSW) Pty Ltd [2011] NSWCA 254

McColl JA, Basten JA and Handley AJA
29 August 2011

The worker made a claim for lump sum compensation for permanent impairment for injuries sustained to his lumbar spine, cervical spine and thoracic spine.

Upon medical assessment, the Approved Medical Specialist (AMS) certified the worker to be suffering seven per cent whole person impairment of the lumbar spine (following a one-tenth deduction for a pre-existing condition pursuant to s 323 of the 1998 Act), and nil per cent whole person impairment for each of the cervical spine and the thoracic spine.

On medical appeal, a Medical Appeal Panel (the Panel) confirmed the AMS's medical assessment.

By way of judicial review in the Supreme Court, the worker submitted that the decisions of both the AMS and the Panel were infected with an error of law and/or jurisdictional error. The Supreme Court dismissed the action, finding no error of any type in the decisions.

The worker sought leave to appeal to the Court of Appeal on the following grounds:

- a. The AMS erred in not finding any causal connection between the pre-existing condition in the lumbar spine and the impairment consequent upon the compensable injury.
- b. The AMS failed to provide adequate reasons for applying a one-tenth deduction for pre-existing condition in the assessment of the lumbar spine impairment, and in relation to the assessments of the cervical spine and thoracic spine impairments; and
- c. The Panel failed to provide adequate reasons for confirming the AMS's assessment.

The Court of Appeal determined the appeal on several bases, including, as follows:

- a. The worker could not challenge the decision of the AMS by way of judicial review because it was already the subject of a medical appeal before the Panel;
- b. If it were open to the Court to deal with the challenge to the AMS's assessment, the Court would have found no failure on the part of the AMS to make findings of causation, because the AMS was only making sufficient determinations in relation to the deductible proportion due to the pre-existing condition of the lumbar spine;
- c. The AMS was required to provide reasons, but those reasons need not be extensive.

The decision is significant, as it affirms previous authorities on various issues and principles impacting on the roles, functions and powers of an AMS or a Panel.

The Court of Appeal thereby affirms that the AMS has an obligation to provide reasons for findings and determinations in a medical assessment, but that the reasons need not be comprehensible to a person with no medical expertise. If there is no medical evidence provided to an AMS to establish the existence of or the contribution to the impairment by the pre-existing condition, it may be held that the AMS may not be required to provide extensive reasons (even for the benefit of those with medical expertise and knowledge) because the issue before him or her is not "medically contestable".

Basten JA's reasons also reiterate that the supervisory jurisdiction of the courts does not extend to challenges against the original medical assessment.

Lukacevic v Coates Hire Operations Pty Ltd [2011] NSWCA 112

Giles JA, Hodgson JA and Handley AJA

6 May 2011

The worker lodged a medical appeal against the decision of the AMS in a medical assessment of his psychiatric impairment, relying on his own statement to prove that there was additional relevant information pursuant to the ground of appeal under s 327(3)(b) of the 1998 Act.

The matter proceeded to a Panel, which confirmed the AMS's assessment. With respect to the statement, the Panel concluded that the statement should not be received in the appeal as fresh evidence because:

"...the Appellant comments on the process of the medical examination and there is an interest in finality of litigation which admitting the statement would not serve. For reasons of procedural fairness, the Panel could not consider the allegations made by the Appellant in the absence of a response from the AMS. That continual opening and re-opening of the evidence is not in the interest of justice and not contemplated as part of the appeal mechanism in the Commission."

The worker sought judicial review of the Panel's decision in the Supreme Court. The Supreme Court dismissed the worker's summons, on the basis that the Panel did not err in failing to admit the worker's statement as fresh evidence under s 328(3) of the 1998 Act.

In following the principles set out in *Summerfield v Registrar of the Workers Compensation Commission of NSW* [2006] NSWSC 515, the Supreme Court held that the Panel had the discretion to either allow or refuse the worker's statement as fresh evidence in the medical appeal.

On appeal to the Court of Appeal, the worker alleged, *inter alia*, that:

- a. The Supreme Court erred in finding that the Panel had discretion to refuse to admit into the medical appeal proceeding the worker's statement, when that evidence may be adduced as fresh evidence under s 328(3);
- b. Alternatively, if the Panel had that discretion, the Supreme Court erred in finding that the Panel applied the correct test and did not fail to exercise its discretion in finding that the worker's statement would not be considered or admitted because a response would be required from the AMS as a matter of procedural fairness, and that "principles of finality of litigation" required that this does not occur.

The Court of Appeal granted the worker leave to appeal, but dismissed the appeal on several grounds. In a dissenting judgment, Giles JA held that the Panel's decision to refuse the worker's statement for the reasons it gave was one at which no Panel could arrive.

His Honour therefore held that the Panel's decision was *Wednesbury* unreasonable (citing the principle in *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* (1948) 1 KB 223), because the exercise of the discretion to refuse to admit the worker's statement was so unreasonable that no reasonable person could have exercised it.

However, in the majority judgment of Handley AJA (Hodgson JA, concurring), the Court held that there was no denial of procedural fairness and that there was no *Wednesbury* unreasonableness in the decision of the Panel. His Honour found that the worker's statement was not admissible, as it did not satisfy the requirement under s 328(3) of the 1998 Act as fresh evidence, because it only added to the history recorded by the AMS and it was available and could reasonably have been obtained prior to the medical assessment.

Handley AJA also determined that the Panel could not be obliged to receive evidence that was not relevant, because s 328 does not require a Panel to receive new evidence which meets the threshold in sub-s (3) of that provision. The Panel was empowered by WorkCover Guideline 43 to reject irrelevant evidence on discretionary grounds, including whether the "new evidence should be allowed".

The Court of Appeal ultimately found that there is no illegality or irrationality in the Panel's decision, and that there was no error of law on the face of the Panel's record of decision.

The worker's application for special leave to appeal was rejected by the High Court of Australia, without making specific orders or determinations.

The decisions of the Court of Appeal and the Supreme Court offer valuable assistance in clarifying the position that a Panel is not obliged to receive new evidence just because the information meets the requirements of "fresh evidence" under s 328(3) of the 1998 Act. The evidence proffered under that provision must be of such relevance and probative value so as to be admitted into the medical appeal proceeding.



APPENDIX 1

Members of the Commission

President

His Hon Judge Greg Keating

Deputy Presidents

Bill Roche

Kevin O'Grady

Acting Deputy Presidents

Anthony Candy

Lorna McFee

Registrar

Sian Leathem

Senior Arbitrators

Eraine Grotte

Deborah Moore

Michael Snell

Arbitrators

Full-time

Brett Batchelor

Elizabeth Beilby

Garth Brown

Glenn Capel

Christine D'Souza

Grahame Edwards

Kerry Haddock

Michael McGrowdie

Annemarie Nicholl

Jane Peacock

Paul Sweeney

Craig Tanner

Part-time

Ross Bell

Marshal Douglas

Richard Perrignon

Josephine Snell

Sessional

Robert Caddies

Janice Connelly

Margaret Dalley

William Dalley

John Hertzberg

Carol McCaskie (MAP)

Bruce McManamey (MAP)

Peter Molony (MAP)

Dennis Nolan

Jeffrey Phillips SC

Faye Robinson

Carolyn Rimmer

Jennifer Scott

Natasha Serventy

Annette Simpson

John Wright

John Wynyard (MAP)

Leigh Virtue

The Registrar may exercise all the functions of an Arbitrator by operation of s 371(1) of the *Workplace Injury Management and Workers Compensation Act 1998*. The Deputy Registrars also hold Arbitrator appointments.

APPENDIX 2

Approved Medical Specialists

Dr Robert Adler	Dr John Moore Greenaway	Prof George Mendelson	Dr Nicholas A Talley
Dr Timothy Anderson	Dr John Harrison	Dr Patrick John Morris	Dr Stuart Taylor
Dr Peter Anderson	Dr Richard Haber	Dr Paul Christopher Myers	Dr Graham Vickery
Dr John Ashwell	Dr Scott Harbison	Dr Steven Ng	Dr Harold Waldman
Dr Mohammed Assem	Dr Henley Harrison	Dr Paul Niall	Dr William Walker
Dr John Beer	Dr Philippa Harvey-Sutton	Dr Brian Noll	Dr Tai-Tak Wan
Dr Neil Berry	Dr Robin Higgs	Assoc Prof Robert Oakeshott	Dr George Weisz
Dr Trevor Best	Dr Yiu-Key Ho	Dr Chris Oates	Dr Kalev Wilding
Dr Graham Blom	Dr Peter Holman	Dr David Daniel O'Keefe	Dr Peter Sydney Wilkins
Dr James Bodel	Dr Alan Home	Dr John O'Neill	Dr Brian Williams
Dr Anthony Bookallil	Dr Nigel Hope	Dr Kim Ostinga	
Dr Kenneth Brearley	Dr Kenneth Howison	Dr Julian Parmegiani	
Dr Robert Breit	Dr Murray Hyde Page	Dr Brian Parsonage	
Dr Frank Breslin	Dr Peter L Isbister	Dr Robert Payten	
Dr David Bryant	Dr Anthony Johnson	Dr Roger Pillemer	
Dr Peter Burke	Dr Lorraine Jones	Dr Graham Pittar	
Dr Mark Burns	Dr Sornalingam Kamalaharan	Dr Stuart Porges	
Dr William Bye	Dr Hari Kapila	Dr Thandavan B Raj	
Dr Christopher W Clarke	Dr Gregory Kaufman	Dr Loretta Reiter	
Assoc Prof W Bruce Conolly	Dr Peter Klug	Dr Michael Robertson	
Dr Richard Crane	Dr Edward Korb	Dr Michael Rochford	
Dr David Crocker	Dr Lana Kossoff	Dr Norman Robert Rose	
Dr John Cummine	Dr Damodaran Prem Kumar	Dr Tom Rosenthal	
Dr Michael Davies	Dr Sophia Lahz	Dr Roger Rowe	
Dr Thomas Davis	Dr William Lennon	Assoc Prof Michael Ryan	
Dr Michael Delaney	Dr Michael Long	Dr Avtar Sachdev	
Dr Drew Dixon	Dr Ivan Lorentz	Dr Philip Sambrook	
Dr John Dixon-Hughes	Dr William Lyons	Dr Edward Schutz	
Dr Hugh English	Dr David Macauley	Dr Joseph Scoppa	
Dr Donald Kingsley Faithfull	Dr Nigel Marsh	Dr James Scougall	
Assoc Prof Michael Fearnside	Dr Tommasino Mastroianni	Dr Thomas Silva	
Dr Antonio E L Fernandes	Dr Andrew McClure	Dr Andrew Singer	
Dr Sylvester Fernandes	Dr Gregory McGroder	Dr John H Silver	
Dr Robin B Fitzsimons	Dr John D McKee	Dr John Sippe	
Dr Susanne Freeman	Dr Ross Mellick	Dr David Sonabend	
Dr Hunter Fry	Dr Roland Middleton	Dr Gregory Steele	
Dr John F W Garvey	Dr Frank Machart	Dr Michael Steiner	
Dr Robert Gertler	Dr Wayne Mason	Dr John P H Stephen	
Dr Peter Giblin	Dr Ross Mills	Dr J Brian Stephenson	
Dr Dolores Gillam	Dr Michael McGlynn	Dr Harry Stern	
Dr Michael Gliksman	Dr David McGrath	Dr John Robert Strum	
Dr Nicholas Glozier	Dr Ian Meakin	Dr Geoffrey Stubbs	
Dr David Gorman	Dr Allan Meares	Dr Stanley Stylys	

APPENDIX 3

Mediators

Robyn Bailey
Ross Bell
Jak Callaway
Geoff Charlton
Janice Connelly
Jennifer David
Marshal Douglas
Geri Ettinger
Robert Foggo
David Flynn
David Francis
Nina Harding
John Hertzberg
John Ireland
Katherine Johnson
James Kearney
John Keogh
Stephen Lancken
Margaret McCue
John McDermott
Ross MacDonald
John McGruther
Garry McIlwaine
Janice McLeay
Chris Messenger
Dennis Nolan
Jennifer Scott
John Weingarth

APPENDIX 4

Medical Appeal Panel Appointments

Medical Appeal Panel Approved Medical Specialists

Dr John Ashwell
Dr James Bodel
Dr Anthony Bookallil
Dr Robert Breit
Dr David Bryant
Dr Peter Burke
Dr Mark Burns
Dr Richard Crane
Dr David Crocker
Dr Michael Davies
Dr John Dixon-Hughes
Dr Michael Fearnside
Dr Robert Gertler
Dr Nicholas Glozier
Dr Philippa Harvey-Sutton
Dr Peter Isbister
Dr Lana Kossoff
Dr Sophia Lahz
Dr William Lyons
Dr Gregory McGroder
Dr Ross Mellick
Dr Paul Niall
Dr Brian Noll
Dr Robert Oakeshott
Dr Julian Parmegiani
Dr Roger Pillemer
Dr Joseph Scoppa
Dr James Scougall
Dr Gregory Steel
Dr John Brian Stephenson
Dr Graham Vickery
Dr Brian Williams

Medical Appeal Panel Supplementary Approved Medical Specialists

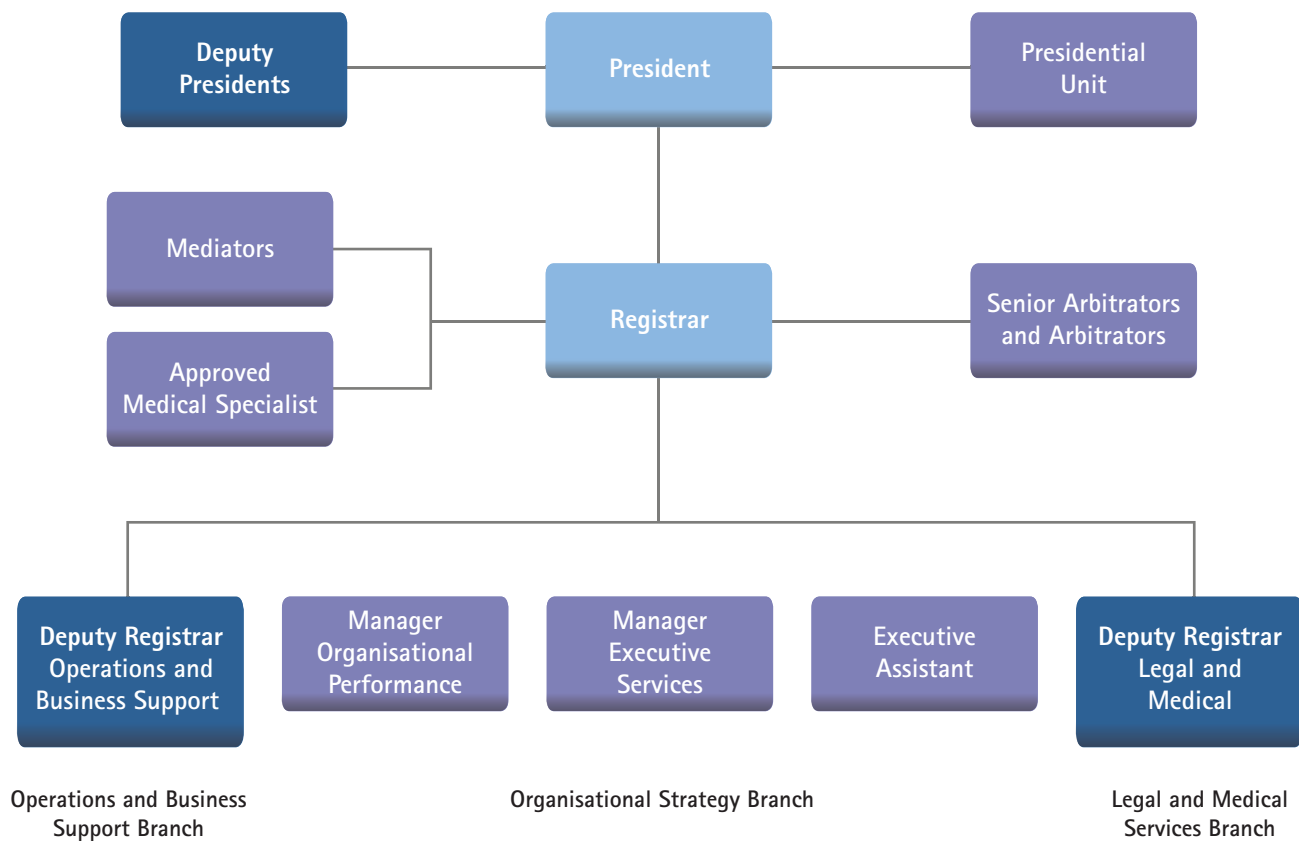
Dr Peter Anderson
Dr Mohammed Assem
Dr Neil Berry
Dr Frank Breslin
Dr Geoffrey Boyce
Dr Michael Delaney
Dr John Duggan
Dr Antonio E L Fernandes
Dr Sylvester Fernandes
Dr Robin Fitzsimons
Dr Susanne Freeman
Dr Hunter Fry
Dr John Garvey
Dr Michael Gliksman
Dr Richard Haber
Dr Henley Harrison
Dr Scott Harbison
Dr Anthony Johnson
Dr Gregory Kaufman
Dr Edward Korbel
Dr David Macauley
Dr Frank Machart
Dr Nigel Marsh
Dr Wayne Mason
Dr Tommasino Mastroianni
Dr Ross Mills
Dr Patrick Morris
Dr Paul Myers
Dr Brian Parsonage
Dr Robert Payten
Dr Graham Pittar
Dr Stuart Porges
Dr Thandavan Raj
Dr Michael Robertson
Dr Tom Rosenthal
Dr Avtar Sachdev
Dr Harry Stern
Dr Stanley Styliis
Dr Nicholas Talley
Dr Stuart Taylor
Dr William Walker

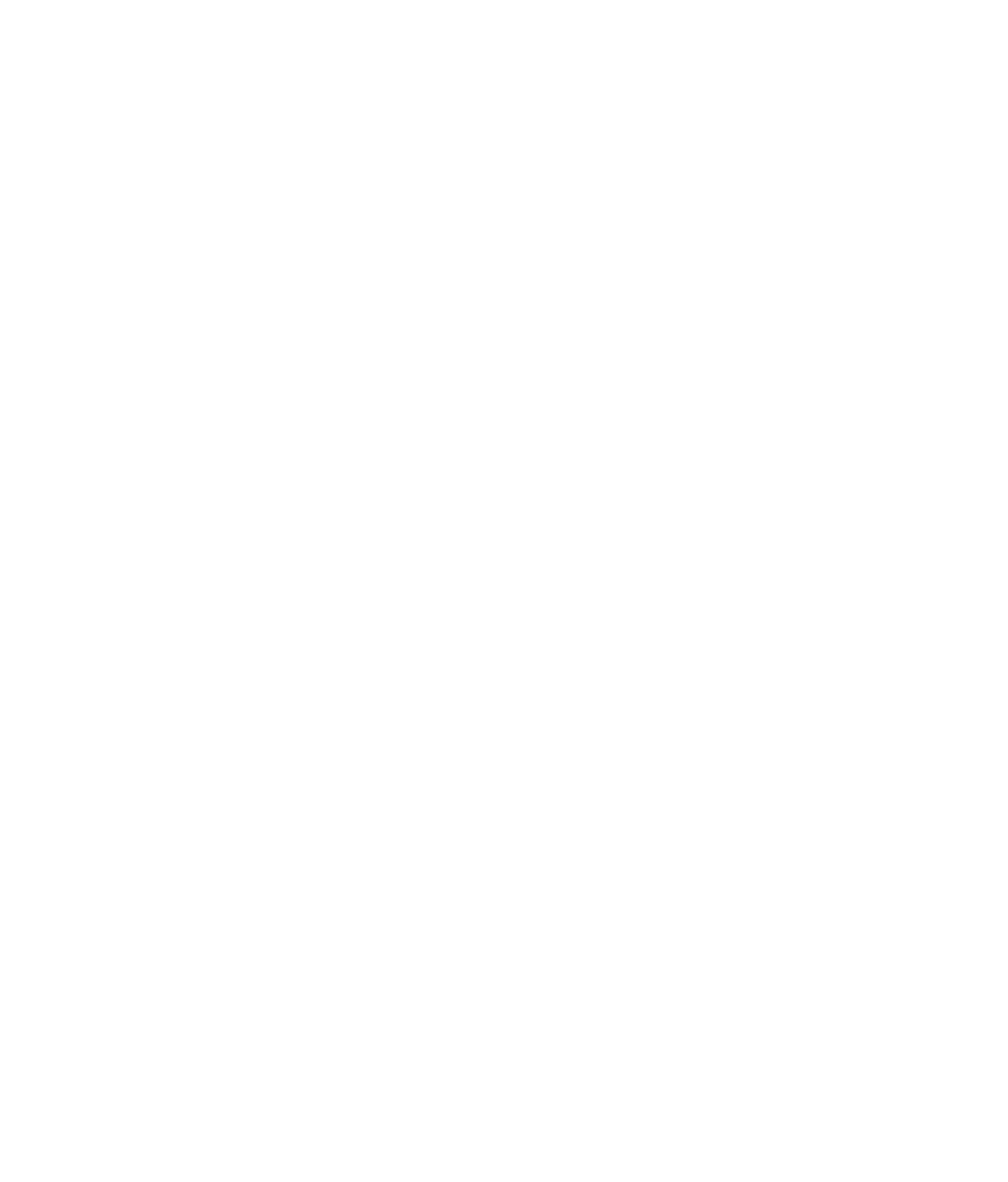
Medical Appeal Panel Convenors

Ms Carol McCaskie
Mr Bruce McManamey
Mr Peter Molony
Mr John Wynyard
Ms Carolyn Rimmer
Ms Natasha Serventy

APPENDIX 5

WCC Organisational Chart









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