WORKERS COMPENSATION COMMISSION

STATEMENT OF REASONS FOR DECISION OF THE APPEAL PANEL IN RELATION TO A MEDICAL DISPUTE

Matter Number:	**M1-3732/20**
Appellant:	**Kenneth John Whitton**
Respondent:	**McKinlay Enterprises**
Date of Decision:	**17 February 2021**
Citation No:	**[2021] NSWWCCMA 34**

Appeal Panel:	
Arbitrator:	**Jane Peacock**
Approved Medical Specialist:	**Dr Julian Parmegiani**
Approved Medical Specialist:	**Dr Douglas Andrews**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 26 October 2020, Mr Kenneth John Whitton (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Patrick Morris, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 28 September 2020.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

   - availability of additional relevant information (being additional information that was not available to, and that could not reasonably have been obtained by, the appellant before the medical assessment appealed against);

   - the assessment was made on the basis of incorrect criteria, and

   - the MAC contains a demonstrable error.

3. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground(s) of appeal on which the appeal is made.

4. The Workers compensation medical dispute assessment guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the Workers compensation medical dispute assessment guidelines.

5. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* ed 1 April 2016 (the Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

PRELIMINARY REVIEW

6. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Workers compensation medical dispute assessment guidelines.

7. As a result of the Appeal Panel's preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination.

Fresh evidence

8. Section 328(3) of the 1998 Act provides that evidence that is fresh evidence or evidence in addition to or in substitution for the evidence received in relation to a medical assessment appealed against may not be given on an appeal by a party unless the evidence was not available to the party before the medical assessment and could not reasonably have been obtained by the party before that medical assessment.

9. The appellant seeks to admit the following evidence:

   (a) Statement of the appellant dated 23 October 2020 and report Ms Angela Andres dated 25 October 2020.

10. The McKinlay Enterprises (the respondent) objects to the admission of fresh evidence

11. The Appeal Panel determines that the following evidence should not be received on the appeal:

    (a) Statement of the appellant dated 23 October 2020 and report of Ms Angela Andrews dated 25 October 2020.

12. The evidence primarily concerns the assessment process itself as conducted by the AMS. The conduct of the clinical examination is a matter for the approved medical specialist, using his clinical expertise, on the day of the assessment.

EVIDENCE

Documentary evidence

13. The Appeal Panel has before it all the documents that were sent to the AMS for the original medical assessment as well as the statement of evidence admitted above and has taken them into account in making this determination.

Medical Assessment Certificate

14. The parts of the medical certificate given by the AMS that are relevant to the appeal are set out, where relevant, in the body of this decision.

SUBMISSIONS

15. Both parties made written submissions. They are not repeated in full but have been considered by the Appeal Panel.

FINDINGS AND REASONS

16. The procedures on appeal are contained in s 328 of the 1998 Act. The appeal is to be by way of review of the original medical assessment, but the review is limited to the grounds of appeal on which the appeal is made.

17. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 the Court of Appeal held that the Appeal Panel is obliged to give reasons. Where there are disputes of fact it may be necessary to refer to evidence or other material on which findings are based, but the extent to which this is necessary will vary from case to case. Where more than one conclusion is open, it will be necessary to explain why one conclusion is preferred. On the other hand, the reasons need not be extensive or provide a detailed explanation of the criteria applied by the medical professionals in reaching a professional judgement.

18. The matter was referred by the Registrar to the AMS for assessment ((s 319 of the 1998 Act) as follows:

- **Date of injury:** **25 March 2018**
- **Body parts referred:** **Psychiatric/psychological disorder**
- **Method of assessment:** **Whole Person Impairment**

19. The AMS issued a MAC certifying as follows:

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in NSW workers compensation guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5 Guides**	**% WPI**	**WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality** (expressed as a fraction)	**Sub-total/s % WPI** (after any deductions in column 6)
1. Psychiatric / Psychological	25 March 2018	Chapter 11, Work Cover Guides	n/a	9%	n/a	9%
Total % WPI (the Combined Table values of all sub-totals)					**9%**	

20. The assessment was based on an assessment by the AMS conducted under the permanent impairment ratings scale (PIRS), as set out in the following table:

Name	Kenneth John Whitton	Claim reference number (if known)	3732/20
DOB	12 November 1956	Age at time of injury	61 years old
Date of Injury	25 March 2018	Occupation at time of injury	Service Station Attendant
Date of Assessment	18 September 2020	Marital Status before injury	Married

Psychiatric diagnoses	1.Posttraumatic Stress Disorder.	
	2.Major Depressive Disorder.	
Psychiatric treatment	Sees mental health social worker two to three weekly; has consultations with treating psychiatrist about every two months. Is not taking medication.	
Is impairment permanent?	Yes	

PIRS Category	Class	Reason for Decision
Self-Care and personal hygiene	2	Mild impairment. Mr Whitton reports showering on a daily basis. He assists his wife with the shopping. She does the cooking, clothes washing and house cleaning and he does the lawn mowing and the outside home maintenance. He was well groomed at the assessment.
Social and recreational activities	3	Moderate impairment. Mr Whitton reports remaining generally quiet and withdrawn at home. He stopped attending boxing training which he used to be very involved in. He stopped going to the club on Friday nights to talk and drink with friends. He goes shopping with his wife on a weekly basis. He visits his daughter and her family with his wife at her home about every one or two months. He said his daughter and her children visit him at home on a weekly basis.
Travel	2	Mild impairment. Mr Whitton is only able to drive short distances by himself around his hometown of Casino. For longer distances such as driving to Lismore or Ballina his wife accompanies him because he lacks confidence in his driving.
Social functioning	2	Mild impairment. Mr Whitton reported that his relationship with his wife has been strained by his social withdrawal and irritability, but they are still together with no separations or domestic violence. His said that his relationship with his daughter has been strained by his symptoms but he remains generally good. He said that he has lost all his friendships because of his social withdrawal.
Concentration, persistence and pace	2	Mild impairment. Mr Whitton reports that his concentration is not as good as prior to the accident. He said that he is able to read a newspaper from front to back. He is able to drive from his home to Bangalow which is a drive of about an hour in duration. He is still able to do repairs around the house and put cupboards together and use a power saw. He said that he was able to watch a football game on television which lasted for about two hours. He is able to manage his finances at home in conjunction with his wife. There were no impairments in immediate, short-term memory or concentration on testing at the assessment.
Employability	5	Totally impaired. Mr Whitton is not able to work at all as a result of the severity of the anxiety and depressive symptoms from his Posttraumatic Stress Disorder and Major Depressive Disorder, particularly his hypervigilance, intrusive traumatic memories, depressed mood, lack of motivation and lack of energy.

Score | Median Class

2	2	2	2	3	5		=2

Aggregate Score Impairment | | | | | | Total

+2	+2	+2	+2	+3	+5	=16

Impairment Percentage WPI from table 11.8:	9%
Less pre-existing impairment if any:	Nil
Final Impairment % WPI:	**9%**

21. The AMS made no deduction under s 323 and made no adjustment for the effects of treatment.

22. The worker appealed.

23. The complaints on appeal concern the assessments made by the AMS under the PIRS in respect of one category only, namely Concentration, Persistence and Pace. There was no complaint by either party on appeal about no adjustment being made by the AMS for the effects of treatment. Similarly, there was no complaint on appeal by either party about no deduction under s 323.

24. In summary, the appellant submitted that the AMS erred as follows:

    - in his assessment of Class 2 for concentration, persistence and pace and submitted that it should have been rated as Class 3 or Class 4;
    - in his assessment of Class 2 for concentration, persistence and pace the AMS has made a demonstrable error;
    - in his assessment of Class 2 for concentration, persistence and pace the AMS has made his assessment on the basis of incorrect criteria;
    - in light of the Class 5 rating for employability, the total WPI assessment of 9% seems somewhat incongruous, and
    - the nature of the injury and it's enduring sequalae as evident in the documentary material is at odds with a Class 2 assessment of concentration, persistence and pace.

25. In summary the respondent submitted that the AMS did not apply incorrect criteria nor did he make a demonstrable error and that the MAC should be confirmed.

26. The role of the AMS is to conduct an independent assessment on the day of examination. The AMS is required to take a history, conduct a mental state examination, make a psychiatric diagnosis and have due regard to other evidence and other medical opinion that is before the AMS. The AMS must bring his clinical expertise to bear and exercise his clinical judgement when making an assessment of impairment under the PIRS categories. The assessment is not to be based upon self-report alone. An appeal panel cannot disturb ratings under the PIRS scale for mere difference of opinion but must be satisfied as to error.

27. The assessment was undertaken by audio-visual link in accordance with the Commission's protocols for dealing with matters during the COVID-19 pandemic. The Panel understands that there is inherent difficulty in the assessment process, whether conducted face to face or by means of audio-visual link, for injured workers who have suffered psychological injury. However, the assessment must be undertaken notwithstanding that it may be difficult and this inherent difficulty does not invalidate the process. Moreover, the manner in which the AMS conducts the assessment is a matter within the province of the AMS. The AMS is using his or her clinical expertise in the conduct of the assessment including the mental state examination and as such may ask certain questions and not others for reasons not apparent to a lay person but which are within the clinical domain of the AMS. The assessment is not based on self-report alone rather the AMS is required to exercise his clinical judgment on the day of the examination.

28. The AMS recorded the following history:

> "• **Brief history of the incident/onset of symptoms and of subsequent related events, including treatment:**
>
> Mr Whitton said that he commenced working at the service station where the injury occurred in 2002. He said that he had no problems in his work until the injury occurred.
>
> Mr Whitton said that on 25 March 2018 he was commencing his shift at about 7am. He was by himself when three masked men entered the shop. He was punched, kicked, hit with an iron bar and slashed with a knife across his face. He said the men took the money from the till and left the premises. After they had left he pressed the alarm button and the police came. Ambulance came later and took him to Lismore Hospital. He said that he spent all day in the hospital and required 15 stitches for his facial wounds. He also had bruising in his body and face from being hit with an iron bar and being kicked and punched. He has not returned to work since the assault.
>
> Almost immediately after the assault Mr Whitton started experiencing nightmares related to the assault and had frequently intrusive traumatic memories of the assault. He became depressed and irritable and had very poor sleep. He was seen by a social worker Angela Andrews through Victim Services initially and has continued to see Ms Andrews about every two to three weeks. He said that he finds the sessions helpful in ''calming (him) down'.
>
> Mr Whitton said his GP in Casino Dr Castagna referred him to a psychiatrist Dr Huntsman in Bangalow in October 2018. He has been seeing Dr Huntsman regularly since then and has been having phone consultations about every two months since the start of the COVID-19 pandemic.
>
> Mr Whitton said he has been tried on different medications by his GP and Dr Huntsman but developed side-effects and had to stop taking them. He has been on no medications in 2020.
>
> Mr Whitton said that his symptoms fluctuate in severity from day to day but have been relatively stable this year.
>
> • **Present treatment:**
>
> Mr Whitton sees a mental health social worker, Angela Andrews every two to three weeks for consultations. He has phone consultations with his psychiatrist, Dr Huntsman about every two months. He sees his GP Dr Castagna about every two months. He is not taking any medication."

29. The AMS has taken a history of the worker's self-reported present symptoms as follows:

> "Mr Whitton experiences nightmares relating to the assault that occurred on 25 March 2018 about once or twice per week. He said his sleep is generally very poor and disturbed. He experiences frequent intrusive traumatic memories of the assault on most days. The memories are associated with anger and his eyes watering. The memories are triggered by seeing the scars which he still has on his face from the knife slashing. The memories are also triggered by seeing Aboriginal people in Casino as his three assailants were of Aboriginal background. He tries to avoid thinking and talking about the assault. He tries to avoid reminders of the assault and avoids watching television shows about murders or violent crimes as they trigger memories of the assault. He prefers to stay at home and usually only leaves his home in the company of his wife. He has lost interest in training children in boxing which used to be a big part of his life. He has lost interest in socialising and going out and he avoids crowded places. He has lost trust in Aboriginal people whereas before the assault, he used to have a good relationship with them and had trained many Aboriginal children in boxing. He is hypervigilant and frequently on the lookout for danger. He is jumpy at sudden noises.
>
> Mr Whitton reports feeling depressed and sad '90 percent of the time'. He reports having little pleasure or enjoyment in life now. He reports a reduced appetite but no weight loss. He reports having low energy levels and no motivation. He feels guilty about his response to the assault. He feels hopeless and that life is not worth living and has had occasional suicidal thoughts.
>
> Mr Whitton describes feeling 3 or 4 out of 10 where zero is the worst he could imagine feeling and 10 is how he was feeling prior to the assault on 25 March 2018."

30. The AMS has taken a history of the self-reported impact on the appellant's activities of daily living as follows:

> "Mr Whitton lives with his wife in their own home in Casino. He said that his daughter comes over once or twice per week to visit him. He said his stepson comes over about once a week. He said that he and his wife go out to do the shopping about once a week. He said that his wife now does all the cooking. His wife does the clothes washing and house cleaning and he mows the lawn and does the outside home maintenance. He showers every day. He said that he visits his daughter and grandchildren in Kyogle about every one to two months. He said that he and his wife now eat takeaway food and do not eat out at restaurants anymore. He said that he is only able to travel short distances such as around Casino by himself. For longer distances such as driving to Lismore or Bangalow he needs his wife to accompany him."

31. The AMS conducted a mental state examination and recorded his findings as follows:

> "Mr Whitton was a depressed looking, balding man wearing a t-shirt. He was cooperative but withdrawn in his manner with very little eye contact. His speech was soft and slow. IHis mood was depressed. His affect was appropriate to his mood and unreactive. There was no formal thought disorder and no psychotic symptoms.
>
> Mr Whitton was alert and orientated. He had intact immediate and short-term memory as he could recall 3 out of 3 items immediately and 3 out of 3 items at two-minute recall. His concentration was unimpaired as he performed serial 3 subtractions accurately and his general knowledge was good as he could name the Australian Prime Minister and the NSW Premier."

32. The AMS summarised the injury and his diagnosis as follows:

> "In my opinion Mr Whitton has the psychiatric conditions of Posttraumatic Stress Disorder and Major Depressive Disorder according to DSM-5 diagnostic criteria. These conditions emerged as a result of the violent assault and robbery he was the victim of on 25 March 2018 whilst working as a service station attendant at a service station in Casino. Despite appropriate psychiatric treatment and counselling his condition has remained clinically significant.
>
> - **consistency of presentation**
>
> Mr Whitton was consistent in his presentation of his history and symptoms. He did not appear to be exaggerating or minimising his clinical condition."

33. The AMS has had regard to the other evidence that was before him. He specifically notes and explains why his opinion differs from that of the independent medical expert for the appellant Dr Huntsman in respect of the various PIRS categories including the one complained about on appeal namely Concentration, Persistence and Pace:

> "I note a report on Mr Whitton by Dr Graham Vickery, psychiatrist dated 14 October 2019. Dr Vickery noted that at that time Mr Whitton was taking the SNRI antidepressant medication Duloxetine. (I note that Mr Whitton is not on any medication now.) Dr Vickery made a diagnosis of Posttraumatic Stress Disorder in Mr Whitton. Dr Vickery was of the opinion then that Mr Whitton's condition had not reached maximum medical improvement and recommended a review in 12 months.
>
> I am of the opinion that Mr Whitton's condition has reached maximum medical improvement. Since he was assessed by Dr Vickery Mr Whitton has continued to receive treatment from his counsellor, Ms Angela Andrews and has continued to see his treating psychiatrist Dr Stephen Huntsman. He has not been able to tolerate medication for his condition. I believe his condition is unlikely to change substantially in the next 12 months. I note in any case that it is now 11 months since Mr Whitton was assessed by Dr Vickery.
>
> I note a number of letters and reports on Mr Whitton written by Ms Angela Andrews, mental health social worker. I note a report dated 16 July 2018 in which Ms Andrews wrote, '…Ken was referred to me by Victim Services for therapy due to the traumatic incident at his place of work. He has now attended six sessions. This serious assault caused him poor sleep, nightmares, flashbacks, panic attacks and extreme anxiety. At the time of the robbery there was shouting, punching and stabbing that was life threatening. Ken is suffering grief and loss of his workplace and depressed that he cannot go back to his previous workplace or any work at this point in time'. Ms Andrews also wrote, '…I will continue sessions with Ken using a combination of therapies, but predominantly Interpersonal Counselling and Cognitive Behaviour Therapy. Strategies for anxiety and panic attacks include breathing exercises, relaxation, mindfulness and gradual exposure to small activities in the community. I employ cognitive work in the areas of self-esteem and positive thought change'. In my opinion these treatment strategies were appropriate for Mr Whitton's psychiatric condition.
>
> I note a letter from Ms Angela Andrews to Dr Stephen Huntsman regarding Mr Whitton dated 26 October 2018. Ms Andrews wrote that Mr Whitton had attended 12 sessions of therapy with her at that time.

I note a report on Mr Whitton by his treating psychiatrist Dr Stephen Huntsman dated 18 July 2019. Dr Huntsman wrote that he initially assessed Mr Whitton on 30 October 2018 after he was referred for treatment by his general practitioner Dr Castagna. Dr Huntsman said that he had subsequently reviewed him on 21/11/2018, 20/12/2018, 17/01/2019, 25/03/2019 and 07/06/2019. Dr Huntsman made diagnoses of Posttraumatic Stress Disorder, chronic and Major Depressive Disorder, single episode in Mr Whitton. Dr Huntsman wrote, '…Mr Whitton's symptoms have remained chronic and persistent despite fairly intensive trauma-focussed therapy from his treating psychologist. At the same time, he has been unable to tolerate antidepressant medication and is now reluctant to take medication again, because of a fear of adverse (side) effects. In my opinion, there is little likelihood of recovery from his symptoms and I would regard his prognosis as poor.'

Dr Huntsman made a final whole person impairment rating of 23% in Mr Whitton. Where Dr Huntsman differed in his assessments from me for Mr Whitton were in the ratings of Travel where he rated Mr Whitton a Class 3, whereas I rated him a Class 2. I rated Mr Whitton a Class 2 as he is able to travel short distances by himself such as in his hometown of Casino. Dr Huntsman rated Mr Whitton a Class 3 for Concentration Persistence and Pace whereas I rated him a Class 2. I rated Mr Whitton a Class 2 as he reports being able to read a newspaper from front to back at a sitting. He is able to drive from his home in Casino to Bangalow which is a drive of an hour's duration. He is able to manage his finances with his wife. He said that he is able to do repairs around the house and put cupboards together and use a power saw. I believe this is best reflected as Mild rather than Moderate impairment in this category. Dr Huntsman made a 1% adjustment for the effects of treatment. I did not make an adjustment for the effects of treatment as in my opinion, there has been no apparent substantial or total elimination of his level of permanent impairment due to his long-term psychiatric treatment. I also note that Mr Whitton has not been able to take medication for his condition.

I note a supplementary report on Mr Whitton by Dr Huntsman dated 16 January 2020. Dr Huntsman wrote, '…Since my previous assessment, Mr Whitton has made minimal progress'. Dr Huntsman noted that Mr Whitton was taking the antidepressant medication Duloxetine but had developed nausea and had stopped this as a result, on the advice of his general practitioner. Dr Huntsman made diagnoses of Posttraumatic Stress Disorder, chronic and Major Depressive Disorder, single episode, in partial remission in Mr Whitton. Dr Huntsman wrote, '…in my opinion Mr Whitton's condition has been unchanged for greater than three months and is unlikely to improve by 3% or more, over the next 12 months, even with maximum treatment'. I am also of the opinion that Mr Whitton has reached maximum medical improvement.

I note a report on Mr Whitton by Dr Peter Snowdon, psychiatrist in his role as an Injury Management Consultant, dated 18 March 2019. Dr Snowdon referred in detail to the treatment that Mr Whitton has received. Dr Snowdon referred to Mr Whitton having been treated with the antidepressant medications Efexor-XR and Escitalopram. I note that Mr Whitton said that he developed side-effects to all the antidepressant medications that he has been prescribed and is therefore not taking any medication currently."

34. In respect of the category Concentration, Persistence and Pace, the Guides provide in Table 11.5 as follows:

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to pass a TAFE or university course within normal time frame.

Class 2	Mild impairment: can undertake a basic retraining course, or a standard course at a slower pace. Can focus on intellectually demanding tasks for periods of up to 30 minutes, then feels fatigued or develops headache.
Class 3	Moderate impairment: unable to read more than newspaper articles. Finds it difficult to follow complex instructions (eg operating manuals, building plans), make significant repairs to motor vehicle, type long documents, follow a pattern for making clothes, tapestry or knitting.
Class 4	Severe impairment: can only read a few lines before losing concentration. Difficulties following simple instructions. Concentration deficits obvious even during brief conversation. Unable to live alone, or needs regular assistance from relatives or community services.
Class 5	Totally impaired: needs constant supervision and assistance within institutional setting.

35. The AMS rated a mild impairment of Class 2 explaining his reasons as follows:

> "Mild impairment. Mr Whitton reports that his concentration is not as good as prior to the accident. He said that he is able to read a newspaper from front to back. He is able to drive from his home to Bangalow which is a drive of about an hour in duration. He is still able to do repairs around the house and put cupboards together and use a power saw. He said that he was able to watch a football game on television which lasted for about two hours. He is able to manage his finances at home in conjunction with his wife. There were no impairments in immediate, short-term memory or concentration on testing at the assessment."

36. The AMS noted that Dr Huntsman the IME qualified on behalf of the appellant had rated a moderate impairment at Class 3. The AMS explained why his rating differed as follows:

> "Dr Huntsman rated Mr Whitton a Class 3 for Concentration Persistence and Pace whereas I rated him a Class 2. I rated Mr Whitton a Class 2 as he reports being able to read a newspaper from front to back at a sitting. He is able to drive from his home in Casino to Bangalow which is a drive of an hour's duration. He is able to manage his finances with his wife. He said that he is able to do repairs around the house and put cupboards together and use a power saw. I believe this is best reflected as Mild rather than Moderate impairment in this category."

37. The panel cannot substitute its opinion for that of the AMS absent a demonstrable error by the AMS or assessment on the basis of incorrect criteria. The only complaint on appeal concerns the assessment in the PIRS category of Concentration, Persistence and Pace. The AMS rated a Class 2 mild impairment. The IME for the appellant had rated a moderate impairment or Class 3. The AMS gave reasons why his assessment differed. The AMS reasoning accords with the criteria in the Guides. After careful review of the evidence the Panel can discern no error in the ratings ascribed by the AMS to the category of Concentration, Persistence and Pace complained about on appeal. There was no application of incorrect criteria. The rating was open to the AMS in accordance with the correct application of the criteria in the Guides. The AMS has given reasons for the rating of mild impairment. He has given a clear and reasoned explanation, that is based on the application of his clinical expertise and accords with the criteria set out in the Guidelines. The AMS must rate according to the criteria in the Guides and provide the best fit in each category. He has done so without discernible error. The rating ascribed by the AMS in the category under complaint accord with the criteria for that class. It represents an exercise of the AMS's clinical judgment on the day of examination. The Panel cannot interfere with this rating absent error by the AMS.

38. For these reasons, the Appeal Panel has determined that the MAC issued on 28 September 2020 should be confirmed.

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

G De Paz

Glicerio De Paz
Dispute Support Officer
As delegate of the Registrar