WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

Issued in accordance with section 294 of the *Workplace Injury Management and Workers Compensation Act 1998*

Matter Number: **6651/18**
Applicant: **Brian Andrew Hoysted**
Respondent: **Asbestos Remover & Demolition Contractors Pty Limited**
Date of Determination: **2 July 2019**
Citation: **[2019] NSWWCC 231**

The Commission determines:

1. The applicant sustained a personal injury in the form of a rupture of a congenital right pericallosal aneurysm causing a subarachnoid haemorrhage in the course of his employment with the respondent on 12 February 2010 within the meaning of section 4(a) of the *Workers Compensation Act 1987*.

2. The applicant's employment with the respondent was not a substantial contributing factor to the injury within the meaning of section 9A of the *Workers Compensation Act 1987*.

The Commission orders:

3. Leave is granted to the applicant to amend the Amended Application to Resolve a Dispute dated 18 December 2018 but received in the Commission on 15 January 2019 as follows:

    (a) By correcting the name of the respondent wherever it appears from "Asbestos Removal & Demolition" to "Asbestos Remover & Demolition Contractors Pty Limited".

    (b) By correcting the date of injury and date of compensation claim in Part 4 to read "12 February 2010".

4. Leave is granted to the applicant to amend the applicant's Wages Schedule dated 21 February 2019 as follows:

    (a) By correcting the commencement date in table 1 relating to weekly benefits compensation to read "12 February 2010".

    (b) By correcting the commencement date in table 2a relating to schedule of earnings pre-2012 amending Act to read "12 February 2010".

5. Award for the respondent.

A brief statement is attached setting out the Commission's reasons for the determination.

Anthony Scarcella
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OFANTHONY SCARCELLA, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Mr Brian Andrew Hoysted, is a 56-year-old man who was the sole director and an employee of Asbestos Remover & Demolition Contractors Pty Limited (the respondent).

2. On 12 February 2010, Mr Hoysted alleges that, whilst working for the respondent on site at the Thurgoona Plaza redevelopment, he suffered a ruptured cerebral aneurism resulting in a subarachnoid haemorrhage.

3. On 11 January 2011, Mr Hoysted submitted a claim for weekly benefits compensation and treatment and related expenses pursuant to the *Workers Compensation Act 1987* (the 1987 Act) to the respondent's insurer, CGU Workers Compensation Insurance (NSW) Limited (CGU).

4. On 18 January 2011, CGU issued a notification to Mr Hoysted of its inability to accept provisional liability and setting out the necessary requirements to enable it to determine provisional liability.[1]

5. On 22 August 2017, the respondent, through CGU, issued a Notice pursuant to section 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) disputing Mr Hoysted's alleged subarachnoid haemorrhage and ruptured cerebral aneurism injury on 12 February 2010.[2] The section 74 Notice was apparently issued in response to a renewed claim for compensation by Mr Hoysted in 2017. The respondent disputed liability on the basis that Mr Hoysted had not suffered an injury arising out of or in the course of his employment with the respondent within the meaning of section 4(a), section 9A, section 4(b)(i) and section 9B of the 1987 Act and that as a result, he was not incapacitated within the meaning of section 33 of the 1987 Act and not entitled to weekly compensation and medical treatment pursuant to section 60 of the 1987 Act. Of course, the declinature on the basis of section 9B of the 1987 Act was misconceived, as the latter section does not apply to injuries prior to the 2012 legislative amendments.

6. There are no communications in evidence between Mr Hoysted and CGU during the period 19 January 2011 and 21 August 2017.

7. On 12 October 2017, the respondent, through CGU issued a Notice pursuant to section 74 of the 1998 Act disputing Mr Hoysted's alleged subarachnoid haemorrhage and ruptured cerebral aneurism injury on 12 February 2010 on the same basis as its section 74 Notice dated 22 August 2017, but in addition, raised section 4(b)(ii) of the 1987 Act.[3]

8. The Application to Resolve a Dispute (ARD) dated 18 December 2018 was registered in the Commission. The ARD incorrectly pleaded the date of injury as 20 February 2010; described the injury as a subarachnoid haemorrhage; and provided the following description of how the injury occurred:

> "The Applicant was loading/unloading the truck and otherwise working in the hot sun for several hours."

9. The Reply dated 24 December 2018 was received in the Commission.

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[1] Reply at pages 42-43
[2] Reply at pages 47-50
[3] Reply at pages 51-56

10. An Amended ARD without supporting documents was received in the Commission on 15 January 2019. The Amended ARD relied upon the same supporting documents listed in the original ARD. The Amended ARD again incorrectly pleaded the date of injury as 20 February 2010; described the injury as a subarachnoid haemorrhage; and provided the following amended description of how the injury occurred:

> "The Applicant was required to work in a plastic hardhat in direct sunlight on a hot tin roof for 2 weeks. On 20 February 2010, the Applicant was loading/unloading the truck and otherwise working in the hot sun for several hours before necessitating hospital consultation for the above injury."

ISSUES FOR DETERMINATION

11. The parties agree that the following issues remain in dispute:

    (a) Whether Mr Hoysted suffered a ruptured cerebral aneurism and a subarachnoid haemorrhage on 12 February 2010 within the meaning of sections 4(a) and 9A of the 1987 Act.

    (b) Whether Mr Hoysted is entitled to weekly payments for total or partial incapacity within the meaning of section 33 of the 1987 Act during the periods claimed.

    (c) Whether Mr Hoysted's medical and related treatment expenses were reasonably necessary as a result of injury within the meaning of section 60 of the 1987 Act.

Matters previously notified as disputed

12. The issues in dispute were notified in Notices pursuant to section 74 of the 1998 Act dated 22 August 2017 and 12 October 2017.

Matters not previously notified

13. No other issues were raised.

PROCEDURE BEFORE THE COMMISSION

14. The parties attended a conciliation conference/arbitration in Albury on 6 May 2019. Mr Ty Hickey of counsel appeared for Mr Hoysted and Ms Kayte Hogan of counsel appeared for the respondent.

15. During the conciliation phase the parties agreed as follows:

    (a) The correct name of the respondent is Asbestos Remover & Demolition Contractors Pty Limited. By consent, the applicant was granted leave to amend the Amended ARD accordingly.

    (b) The correct date of injury and date of compensation claim is 12 February 2010. By consent, the applicant was granted leave to amend the Amended ARD and applicant's Wages Schedule accordingly.

    (c) The applicant's comparable weekly earnings prior to 1 January 2013 would require determination on the available evidence.

    (d) The applicant's pre-injury average weekly earnings on and from 1 January 2013 to 30 June 2014 would require determination on the available evidence.

16. During the course of the respondent's submissions, certain submissions were made which may be summarised as follows:

    (a) There was an alleged frank incident on 12 February 2010 where there was a sub-arachnoid haemorrhage. Mr Hoysted then underwent a further surgical procedure to treat two other aneurysms. If there was a finding that the incident on 12 February 2010 was related to employment and that employment was a substantial contributing factor, then Mr Hoysted's incapacity following the second surgery should not be compensated, as it is not related to the frank incident. Those two aneurysms were underlying conditions.

    (b) Mr Hoysted's incapacity for work is related to the two surgical procedures he underwent, which were not work-related.

17. At the conclusion of the respondent's submissions, Mr Hoysted, through his counsel, Mr Hickey, objected to such submissions as raising new issues not previously raised in any of the respondent's three section 74 Notices. Such interlocutory matter was discussed and could not be resolved. The interlocutory issue was determined by me during the arbitration phase after hearing the oral submissions of the parties and I determined that the respondent could not, at this late stage, raise the issue in the submissions referred to above. Accordingly, I did not take into account the submissions made by the respondent in this regard.

18. The oral submissions and my reasons for the determination in relation to the interlocutory issue were sound recorded and the sound recording is available to the parties.

19. During the conciliation phase an interlocutory dispute arose in relation to the absence of the applicant's St Vincent's Hospital clinical records referred to in the section 74 Notice dated 22 August 2017 and was resolved by me making the following directions on 6 May 2019:

    "1. The respondent is to lodge and serve copies of the applicant's St Vincent's Hospital clinical notes and records referred to in its Notice pursuant to section 74 of the *Workplace Injury Management and Workers Compensation Act 1998* dated 22 August 2017 by way of an Application to Admit Late Documents by 13 May 2019, if such documents are in its possession.

    2. The applicant is to lodge and serve by 20 May 2019 written submissions on any such St Vincent's Hospital clinical notes and records produced.

    3. The respondent is to lodge and serve by 27 May 2019 written submissions in reply.

    4. The parties are to notify the Registrar by email in the event the applicant's St Vincent's Hospital clinical notes and records cannot be produced.

    5. At the conclusion of the time allowed for submissions the dispute will be determined 'on the papers'."

20. The applicant did not lodge written submissions in accordance with direction 2. The respondent complied with directions 1 and 3 and lodged written submissions dated 27 May 2019. As a result of the matters raised in the respondent's written submissions, I issued the following directions on 28 May 2019:

    "1. In compliance with the directions made in this matter on 6 May 2019, the respondent lodged written submissions on 27 May 2019. The latter written submissions included matters which had not been raised in oral submissions at the arbitration. Accordingly, as a matter of procedural fairness, the applicant is directed to lodge and serve by 4 June 2019 any written submissions in reply.

2. At the conclusion of the time allowed for submissions the dispute will be determined 'on the papers'."

21. The applicant did not lodge written submissions in response to the respondent's written submissions dated 27 May 2019 until 18 June 2019, being two weeks later than directed by me on 28 May 2019. Through the Commission, I requested the applicant to explain the reasons for such delay. On 24 June 2019, the applicant provided an explanation, which I accepted and, as I had not completed my written determination and the respondent had, in its submissions, invited a response, I took the applicant's late submissions into consideration.

22. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Documentary evidence

23. The following documents were in evidence before the Commission and taken into account in making this determination:

    (a) ARD dated 18 December 2018 and attached documents;

    (b) Reply dated 24 December 2018 and attached documents;

    (c) Amended ARD dated 18 December 2018 but received in the Commission on 15 January 2019 without attached documents;

    (d) Applicant's Wages Schedule dated 21 February 2019;

    (e) Respondent's Application to Admit Late Documents dated 13 May 2019.

Oral evidence

24. Neither party sought leave to adduce oral evidence from or to cross-examine any witness.

AN ANALYSIS OF THE EVIDENCE

Mr Brian Andrew Hoysted

25. In evidence, there are statements by Mr Hoysted dated 3 May 2017[4] and 8 October 2018[5]. I will now refer to the relevant parts of Mr Hoysted's statements.

26. Mr Hoysted's statement dated 3 May 2017 was provided to an investigator engaged by CGU. Mr Hoysted's statement dated 8 October 2018 was provided to his lawyer.

27. In his evidentiary statements, Mr Hoysted provided details of his educational and employment histories.[6]

28. Mr Hoysted described the circumstances surrounding the commencement of his employment with the respondent in July 2007 as follows:

[4] Reply at pages 65-72
[5] ARD at pages 33-36
[6] Reply at page 66 at [11] and ARD at pages 33-34 at [5]-[20]

> "In 2007, I decided to start my own company, I did this out of frustration of working for other companies and their disorganisation. I started up Asbestos Remover and Demolition Contractors Pty Ltd (ABN 74 124 019 101). The company is [sic] office is located at 298 Dights Forest Road Jindera. The company specialises in demolition of buildings and removal of Asbestos. The company conducts services for both domestic and commercial clients."[7]

29. Mr Hoysted stated that he was the sole director of the respondent company and hired casual employees or contractors as required. His duties for the respondent included all the administrative duties; client liaison; marketing; planning and carrying out of demolition; planning and carrying out asbestos removal; staff hiring and supervision; training and machine operation. He usually worked 12 to 14 hours each day, during which time his duties could include physical activity, mechanical maintenance and administration.

30. In his evidentiary statement dated 8 October 2018, Mr Hoysted stated that he had been working for the respondent at the Thurgoona Plaza redevelopment site from about late January 2010. He worked all day on a hot tin roof removing roofing at the site. On 12 February 2010, he was working at the Thurgoona Plaza redevelopment site supervising the removal of demolition refuse that his team had previously demolished, as well as assisting with the cartage and loading. He stated:

> "… I was under a lot of stress as I had to ensure that all the work was done within a time limit. I was also trying to organise the additional funds from the bank so that wages could be paid. I had a headache that had been getting progressively worse during the day, but I needed to ensure that the job was completed."[8]

Mr Hoysted's description of the events which occurred at about 2.00 pm on 12 February 2010 was similar to that in his evidentiary statement dated 3 May 2017.

31. In his evidentiary statement dated 3 May 2017, Mr Hoysted stated that, on 12 February 2010, he was working for the respondent at the Thurgoona Plaza redevelopment site. He commenced his duties at 7.00 am. It was a hot day. He was working outside for most of the day. He was wearing a plastic construction hardhat with a shaded brim at all times. During the course of most of the morning, he was supervising the loading of trucks that were removing demolition material from a portion of the site they had previously demolished. Mr Hoysted also stated that:

> "22. It was around 2.00pm (or mid-afternoon) that I was organising and supervising the loading of salvage material onto a semi-trailer (recycled building material customer [sic]). I was standing on the ground and supervising the use of an excavator to load the material.
>
> 23. All of a sudden, my head felt really hot, it felt as though it was going to explode. There was no warning that this was going to occur. Along with these symptoms was a massive headache. I felt very unstable and very, very hot. My whole body felt hot but it was mainly my head. I immediately started to walk to the amenities hut and in doing so I was very unstable and wobbly. Ray Spittal (casual employee also loading trucks in the area) observed me having difficulty walking and offered straightaway to take me to Hospital. He said to me that I did not look right.

[7] Reply at page 67 at [12]
[8] ARD at page 34 at [23]

24. I declined his offer, thinking that I had just had a bit too much sun and needed to cool down. I managed to make my way to the amenities hut and stuck my head in the sink under a cold running tap. I removed [sic] short sleeve high-vis shirt, soaked that in water and put it back on. I then proceeded to stand in front of an air conditioner in the hut."[9]

Mr Hoysted felt slightly better but still needed to cool down. So, he sat on a milk crate in a cool room for about 30 minutes at about -5° but left the cool room door open. He left the cool room at about 3.30 pm, feeling a lot better. The pressure in his head had subsided. He drove home.

32. Mr Hoysted stated that upon arriving home on the afternoon of 12 February 2010, he had a shower and lay down. He rested that evening and the following day. On the Sunday immediately following the subject incident, he observed his left arm shaking uncontrollably. He attended the Albury Base Hospital after hours clinic and was diagnosed with neck strain and referred for an MRI scan the following day. After undergoing an MRI scan, he was informed that he had "sustained brain aneurysms".[10] He was immediately referred to the neurological department of St Vincent's Hospital, Melbourne.

33. Mr Hoysted stated that he subsequently underwent a series of angiograms prior to undergoing a surgical repair of an aneurysm on 24 March 2010. About three months later he underwent the surgical repair of another aneurysm.

34. Mr Hoysted stated that he did not return to work for the respondent until December 2010 and thereafter, worked 6 to 8 hours per day, three days per week in "mainly supervisory"[11] duties and struggles with such duties.

35. Mr Hoysted stated that prior to 12 February 2010, he had not suffered any head related illnesses or injuries and that he "was fit and healthy and able to carry out"[12] all his duties. He also stated that he had been undergoing significant stress in the running of his business, including attempting to organise and negotiate an overdraft extension through his bank as well as the stress related to the time constraints for the completion of his work at Thurgoona Plaza redevelopment site.

36. Mr Hoysted described his current situation as suffering from frequent headaches; having to avoid stressful situations; being unable to sleep well; experiencing regular bouts of dizziness; and suffering from anxiety and depression. He consults with his treating neurosurgeons (Dr Christopher Thien and now, Dr Tiew Han) on a regular basis for monitoring purposes and has 24-hour a day access to advice if his condition should deteriorate. He stated that he could not perform his pre-injury duties. He now relies heavily on his son, Earl, to run the respondent's business. However, as Earl is not qualified to run the business, Mr Hoysted needs to be on site to operate it. He also has had to engage other contractors as required.

37. Mr Hoysted stated that he reported the subject incident and injuries to CGU by telephone after he had undergone the surgical procedures referred to above. He was advised to obtain a medical certificate from a general practitioner. However, none were prepared to comment, make a statement or prepare a medical certificate regarding his injuries. He formed the view that none of the general practitioners he had contacted knew enough about the injury and the circumstances to provide the necessary certificates. Accordingly, he gave up because it was merely adding to his stressors at the time.

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[9] Reply at page 68 [22]-[24]
[10] ARD at page 35 at [28]
[11] ARD at page 34 at [20]
[12] Reply at page 67 at [15]

38. Mr Hoysted stated that during one of his consultations with Dr Han in early 2017, he enquired as to whether the latter thought the incident on 12 February 2010 was work-related and described Dr Han's response in the following terms:

> "… he stated that it was definitely work related and he was surprised I had not commenced a claim. I informed him of the difficulties I had had in obtaining the certificates and the fact I had given up. He was adamant that the matter was related to my work and that I could pursue the avenue of Workers Compensation, he was also adamant that I should not be working. He provided a Certificate of Capacity dated 28 March 2017 in which he stated I was unfit for work since March 2010. Dr Han has been involved in my treatment since the operations however we had never discussed the prospect of worker's [sic] compensation previously as other more serious aspects of the injury, my treatment and recovery were the priority."[13]

It was this discussion with Dr Han that caused him to seek advice in relation to pursuing a worker's compensation claim.

39. In relation to his discussion with Dr Han, Mr Hoysted further stated:

> "43. It is my understanding from discussions with Dr Han that both the physical and mental stressors of my work at the time were the major contributing factors in the onset of my injury.
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> 44. At the time, the aneurysm occurred I was simply standing directing staff and the loading of a truck."[14]

Albury Base Hospital Clinical Records

40. In evidence, there are copies of Mr Hoysted's clinical records produced by Albury Base Hospital.[15] I will now refer to relevant parts of the clinical records.

41. On 15 February 2010, Mr Hoysted attended the Albury Base Hospital Emergency Department and consulted Dr Heather Chaffey.[16] Mr Hoysted's presenting problem was recorded as headache. The nursing assessment data recorded four days of left side head numbness with associated left arm pins and needles. He had undergone a CT scan and was awaiting its result. Mr Hoysted expressed concern that he was having a stroke. The records recorded nil by way of allergies or medication. In relation to other personal details, it was recorded that he smoked 30 cigarettes per day; drank three stubbies per day; lived alone; and owned his own demolition company. On examination it was noted, amongst other things, that he had pressured speech and occasionally made inappropriate comments. It was recommended that he undergo an MRI brain scan.

42. On 16 February 2010, Mr Hoysted attended the Albury Base Hospital Emergency Department.[17] Mr Hoysted's presenting problem was recorded as being out in the heat five days previously and thereafter, feeling numbness and tingling in his left hand. The nursing assessment data recorded Mr Hoysted as being very aggressive and demanding to be seen instantly. He was alert and orientated. He complained of headaches when bending over. He was booked in for an MRI brain scan for the following day.

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[13] Reply at page 71 at [40]
[14] Reply at page 71 at [43]-[44]
[15] ARD at pages 11-13; Reply at pages 9-37; and respondent's Application to Admit Late Documents dated 13 May 2019 at pages 1-41
[16] Reply at pages 32-34
[17] Reply at page 31

43. On 17 February 2010, Mr Hoysted attended the Albury Base Hospital Emergency Department.[18] He underwent an MRI brain scan by Dr James Mullins. The result of the MRI brain scan was discussed with Dr Chaffey. He was requested to consult Dr Chris Thien of St Vincent's Hospital, Melbourne. A semi urgent transfer would be arranged within the next one to two days.[19]

44. On 20 February 2010, Mr Hoysted attended the Albury Base Hospital Emergency Department requesting to consult with Dr Chaffey in relation to his recent diagnosis of cerebral aneurysm.[20] He presented as very anxious. He advised that Dr Thien's rooms had not yet contacted him.

45. On 12 March 2010, Mr Hoysted attended the Albury Base Hospital Emergency Department.[21] Mr Hoysted's partner reported that over the past hour, he had been feeling shaky; suffered a loss of motor function; felt warm in his head; and felt as if his legs were dancing. Mr Hoysted complained of a frontal headache and was admitted. The nursing notes recorded that he did not look well. He underwent a CT brain scan on 12 March 2010, following which he was discharged from hospital.

46. On 5 May 2010, Mr Hoysted attended the Albury Base Hospital Emergency Department.[22] The nursing assessment data recorded complaints of a gradual onset of severe occipital headache and photophobia. Mr Hoysted complained that it felt like he had been hit in the back of the head with a hammer. Arrangements were made for him to undergo a CT brain scan.

47. On 29 February 2012, Mr Hoysted attended the Albury Base Hospital Emergency Department with vague symptoms of feeling heat in his head as if he was being scalped; complaints of blurred vision; left sided photophobia; and feeling drunk.[23] The diagnosis of the senior medical officer was one of light-headedness. Mr Hoysted underwent a CT brain scan by Dr Eric Brecher.[24] No acute intracranial pathology was identified. A referral letter was sent to Dr Thien.

Diagnostic imaging and operation reports

48. In evidence, there is an MRI brain scan report by Dr James Mullins dated 17 February 2010.[25] The clinical notes in the report referred to Mr Hoysted's left arm tingling from axilla to fingertips; numbness of the left side of the skull; blurred vision in the left eye; and left arm spasms. Dr Mullins' conclusion was that of a left anterior cerebral artery aneurysm and two small right middle cerebral artery aneurysms.

49. In evidence, there is a CT brain scan report by Dr Charles Lott dated 12 March 2010.[26] The clinical notes in the report referred to the purpose of the scan as being to exclude subarachnoid haemorrhage, noting that there were three known cerebral aneurysms and that Mr Hoysted was presenting with headache. Dr Lott concluded that there was no subarachnoid haemorrhage identified but noted that there was a potential for a false negative CT finding in patients with subarachnoid bleed.

[18] Reply page 26
[19] Reply at page 28
[20] Reply at page 25
[21] Respondent's Application to Admit Late Documents dated 13 May 2019 at pages 30-41
[22] Respondent's Application to Admit Late Documents dated 13 May 2019 at pages 11-18
[23] Respondent's Application to Admit Late Documents dated 13 May 2019 at pages 3-8
[24] Respondent's Application to Admit Late Documents dated 13 May 2019 at pages 9-10
[25] ARD at pages 13-15
[26] ARD at page 15

50. In evidence, there is an operation report by Dr Christopher Thien, Neurosurgeon dated 24 March 2010.[27] Dr Thien noted that Mr Hoysted presented with unruptured aneurysms and an angiogram which had defined a pericallosal aneurysm, a right middle cerebral aneurysm and a supposedly left middle cerebral artery aneurysm. He reported that the most appropriate definitive treatment was to clip the aneurysms. However, because of the small size of the two middle cerebral artery aneurysms, a decision was made to watch those and only clip the pericallosal aneurysm. Dr Thien described the operation procedure itself and performed a craniotomy and clipping of the pericallosal aneurysm. His operative diagnosis was one of pericallosal aneurysm.

51. In evidence, there is a CT brain scan report by Dr Howard Galloway dated 6 May 2010.[28] In his clinical notes, Dr Galloway recorded Mr Hoysted's complaint of occipital headache; past history of cerebral aneurysms, one of which was repaired; and queried intracerebral haemorrhage. Dr Galloway found no evidence of subarachnoid haemorrhage. He reported the non-contrast CT brain scan as normal but added that a normal CT scan does not exclude subarachnoid haemorrhage if performed more than 12 hours after the onset of symptoms.

52. In evidence, there is an operation report by Dr Christopher Thien dated 2 June 2010.[29] Dr Thien performed a right pterional craniotomy and clipping of Mr Hoysted's right middle cerebral artery aneurysm. His operative diagnosis was one of right middle cerebral artery aneurysm.

53. In evidence, there is an MRI and MRA brain scan report by Dr Michelle Thong dated 11 October 2010.[30] Dr Thong recorded the clinical history as being one of recent surgical clipping of right middle cerebral artery aneurysm and pericallosal aneurysm and queried a residual aneurysm neck or new aneurysm. The findings were pericallosal and right middle cerebral artery aneurysm clips with no evidence of a residual aneurysm neck or new intracranial aneurysm. Dr Thong noted that the aneurysm clips could obscure a small residual aneurysm neck.

St Vincent's Hospital Melbourne clinical records

54. In evidence, there are copies of Mr Hoysted's clinical records produced by St Vincent's Hospital, Melbourne.[31] I will now refer to the relevant parts of those clinical records.

55. The clinical records commenced with an entry on 10 March 2010. The last entry related to Mr Hoysted's neurosurgery clinic visit on 28 March 2017. Included in the clinical records were the notes relating to Mr Hoysted's admission prior to and following the surgical procedures on 24 March 2010 and 2 June 2010 and the neurosurgery clinic follow-up visits and investigative procedures thereafter.

56. In its submissions, the respondent drew my attention to an entry in the clinical records on 13 December 2016, which read as follows:

> "been to Slater + Gordon
> wants to claim as WC"[32]

57. The parties did not direct my attention to any other specific entries in the St Vincent's Hospital, Melbourne clinical records.

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[27] ARD at pages 16-17
[28] ARD at pages 18-19
[29] ARD at pages 20-21
[30] ARD at pages 22-23
[31] Respondent's Application to Admit Late Documents dated 13 May 2019 at pages 42-184
[32] Respondent's Application to Admit Late Documents dated 13 May 2019 at page 44

Mr Tiew Han, Neurosurgeon

58. In evidence, there are two Certificates of Capacity issued by Mr Hoysted's current treating neurosurgeon, Mr Tiew Han dated 28 March 2017[33] and 12 September 2017.[34] I will now refer to the relevant parts of those certificates.
59. Mr Han's Certificate of Capacity dated 28 March 2017 provided a description of injury/disease as subarachnoid haemorrhage and a diagnosis of ruptured cerebral aneurysm. The descriptor requesting other details was left blank. The tick boxes relating to the question as to whether the injury/disease was consistent with Mr Hoysted's description of cause were left blank. The treatment was described as craniotomies for clipping two aneurysms. Under the heading "work restrictions", appeared the words: "Aneurysm rupture at work. Unfit for work since 10/3/2010".[35] Mr Han certified Mr Hoysted as unfit for any duties from 28 March 2017 to 24 April 2017.

60. Mr Han's Certificate of Capacity dated 12 September 2017 provided a description of injury/disease as subarachnoid haemorrhage and a diagnosis of ruptured cerebral aneurysm. However, on this occasion, the descriptor referring to other details had the words "work-related stress" included in the appropriate answer box. The treatment was described as craniotomies for clipping two aneurysms. Under the heading "work restrictions", appeared the words: "Aneurysm rupture at work. Unfit for work since 10/3/2010".[36] Mr Han certified Mr Hoysted as unfit for any duties from 12 September 2017 to 10 October 2017.

Associate Professor Michael Fearnside, Neurological Surgeon

61. On 21 June 2018, Mr Hoysted consulted Associate Professor Michael Fearnside, Neurological Surgeon at the request of his lawyers.

62. In evidence, there is a report by Associate Professor Fearnside dated 21 June 2018.[37] I will now refer to the relevant parts of that report.

63. Associate Professor Fearnside took a detailed history from Mr Hoysted, the relevant parts of which may be summarised as follows:

    (a) Prior to suffering the subject subarachnoid haemorrhage in 2010, Mr Hoysted was well, very fit and performing both physical work at work and his activities of daily living without restrictions. There was no prior history of headache, neurological problems or hypertension.

    (b) On 12 February 2010, Mr Hoysted and co-workers were demolishing the Thurgoona Plaza. He was performing heavy manual work on a hot summer's day. The work included demolishing parts of the Plaza and loading the demolished material onto a truck.

    (c) Mr Hoysted was working under considerable pressure to finish the demolition as it was the last scheduled day of the project, so that the builders could commence their work. He was also working under considerable financial pressure because he was unable to pay workers' wages that week. He had four or five workers on the project at the time.

[33] Reply at page 38
[34] Reply at page 39
[35] Reply page 38
[36] Reply page 39
[37] ARD at pages 1-6

(d) At about 2.00 pm on 12 February 2010, after having performed heavy manual work, he felt the sudden onset of a burning pain in his head and felt unstable on his feet, followed by a severe headache. He cooled himself under some cold water, believing that he may have suffered heatstroke. He stood in front of an air conditioner for about 30 minutes and later sat in a cool room. He cooled down and felt a little better. However, the headache continued. He was able to drive himself to his air-conditioned home.

(e) The following day, Mr Hoysted experienced the sudden onset of regular contractions of his left arm and left leg and dizziness. He attended the Emergency Department of the Albury Base Hospital and following a physical examination, he was diagnosed as having strained his neck and scalp muscles. He was booked in for an MRI scan the following day, which demonstrated a subarachnoid haemorrhage. He was referred to St Vincent's Hospital, Melbourne.

(f) On 24 October 2010, Mr Hoysted underwent a craniotomy and clipping of a cerebral aneurysm. This was followed by a further procedure some six months later to clip other cerebral aneurysms.

(g) There was no history of diagnosis or treatment for hypertension, nor was there any history of neurological problems preceding the subject incident.

(h) Between 2010 and 2018, Mr Hoysted experienced anxiety, depression and impairment of concentration. He had some eight months off work following the incident and returned to the same job but there were limits on his capacity to perform the manual work. He remained the proprietor of his company.

(i) There had been no recurrence of the shaking in his left arm and left leg, which Associate Professor Fearnside stated "sounded like a focal epileptic seizure".[38] Mr Hoysted was not treated with any antiepileptic medications and did not take any regular medications except the occasional Panadol over the years and only rarely experienced headache.

64. As to his present condition, Mr Hoysted reported symptoms of anxiety and depression for which he had not received any treatment but rather, had self-managed his symptoms. He also experienced episodes of dizziness and light-headedness with physical activity, which limited his manual work, particularly, lifting or carrying heavy objects. There were no symptoms in his arms or legs. Walking and balance was normal. There was no weakness or sensory loss. He experienced considerable difficulty in focusing on complex projects and when under pressure from building corporations in a very competitive environment. Mr Hoysted reported that he was receiving no specific treatment. He advised that he was under the care of Mr Han upon whom he attended for regular review. He did not undergo regular blood pressure checks and was taking no medications.

65. There were no clinical records from the Albury Base Hospital or St Vincent's Hospital, Melbourne made available to Associate Professor Fearnside.

66. No radiological investigations were available to Associate Professor Fearnside, but he was provided with the MRI brain scan report dated 17 February 2010, the CT brain scan report dated 12 March 2010, the CT brain scan report dated 5 May 2010 and the MRI and MRA brain scan report dated 11 October 2010. Associate Professor Fearnside examined the statement of Mr Hoysted dated 3 May 2017 and the clinical records from Jindera Medical Clinic. In the latter mentioned records, there was no evidence relating to the subarachnoid haemorrhage.

[38] ARD at page 2 at [1.8]

67. On examination, Associate Professor Fearnside observed, amongst other things, that Mr Hoysted was alert and oriented and able to give a good account of himself; he experienced minor unsteadiness and light-headedness when he stood from the sitting position or sat from the lying position; external ocular movements were full; pupillary responses to light were normal; convergence was normal; the lower cranial nerves revealed no abnormality; facial sensation was normal; facial movement was symmetrical; neurological examination of the upper limbs revealed normal tone and power without wasting; reflexes were equal and symmetrical and sensation was intact; neurological examination of the lower limbs revealed normal tone and power without wasting; reflexes were equal and symmetrical; straight leg raising was normal at 90° bilaterally; finger-nose coordination and alternate rapid movements of the fingers were normal.

68. Associate Professor Fearnside stated that it was unclear as to the basis on which the diagnosis of subarachnoid haemorrhage was made. However, he opined that the history of sudden onset of very severe headache was consistent with a diagnosis and that it was probable that Mr Hoysted had sustained a focal seizure the following day when he experienced uncontrollable shaking of his left arm and left leg. The latter symptoms were also consistent with a subarachnoid haemorrhage.

69. Associate Professor Fearnside indicated that a review of the clinical records, particularly from Albury Base Hospital, would be helpful. It does not appear that he was provided with those clinical records and if he was, there is no supplementary report in evidence dealing with the same.

70. In relation to the issue of causation, Associate Professor Fearnside opined, on the balance of probabilities, that it was likely that the nature and conditions of Mr Hoysted's work on 12 February 2010 was a substantial contributing factor to aneurysm rupture. There were a number of comorbid trigger factors. One was hypertension but there was no recorded history of hypertension. He then opined:

> "However, the physical work he was performing could raise his blood pressure and cause the aneurysm rupture."[39]

71. In relation to Mr Hoysted's prognosis, Associate Professor Fearnside opined that it was very favourable and that further subarachnoid haemorrhage was not likely.

72. In relation to fitness for work, Associate Professor Fearnside opined that Mr Hoysted was fit to continue his work in the demolition industry but that he had a limited capacity in respect of physical activity and that he should avoid heavy manual work. He was coping because he was the proprietor of his own company but would struggle to find work on the open labour market.

Dr Dudley O'Sullivan, Neurologist

73. On 27 July 2017, Mr Hoysted consulted Dr Dudley O'Sullivan, Neurologist at the request of CGU's lawyers.

74. In evidence, there is a report by Dr O'Sullivan dated 27 July 2017.[40] There is also a supplementary report dated 17 August 2017.[41] I will now refer to the relevant parts of those reports.

[39] ARD at page 6 at [8.1]
[40] Reply at pages 1-5
[41] Reply at pages 6-8

75. On 27 July 2017, Dr O'Sullivan took a detailed history from Mr Hoysted, the relevant parts of which may be summarised as follows:

(a) On 12 February 2010 at about 2.00 pm, Mr Hoysted was working on a demolition site supervising the loading of salvage material onto a semi-trailer. Suddenly, his head felt very hot and he felt hot all over his body. He also experienced an explosive headache accompanied by nausea. He did not lose consciousness but was unsteady on his feet.

(b) Mr Hoysted went to the site hut where he put his head in cold water, took off his shirt and soaked it in cold water and put it back on again. He stood under an air conditioner.

(c) Mr Hoysted believed he had suffered heatstroke. He went into the cool room of an adjacent supermarket where it was -5° and stayed there for about 30 minutes to an hour. He drank copious amounts of water. Once his body had cooled down, the explosive headache was not as severe. He then drove home.

(d) Upon arriving home, Mr Hoysted lay on the couch under the air-conditioner and remained home for two days resting. On the third day, he was walking on his farm with some visitors and his partner when he developed involuntary movements of the left arm and the left leg together with a tingling sensation in the left hand.

(e) Mr Hoysted was taken to the Albury After Hours Clinic where he was diagnosed as having muscle tension type headaches as well as neck pain. The doctor arranged for him to undergo an MRI scan of his cervical spine and brain the following day. Subsequent investigations established that he had suffered a subarachnoid haemorrhage due to the rupture of a right pericallosal aneurysm. It was also noted that he had two other small right middle cerebral aneurysms and a left anterior communicating aneurysm.

(f) Mr Hoysted consulted Dr Heather Chaffey, General Practitioner at Albury Base Hospital Emergency Department, who confirmed that he had sustained two ruptured brain aneurysms. He was immediately transferred to St Vincent's Hospital, Melbourne under the care of Dr Christopher Thien and underwent a craniotomy and clipping of the right pericallosal aneurysm. He recovered from the surgery. However, due to the presence of the other right middle cerebral artery aneurysm, he underwent an elective clipping of it in June 2010. He recovered reasonably well from the major surgery.

(g) Since surgery, Mr Hoysted still experiences occasional stabbing pain in the head. Headache becomes worse if his stress levels build up. If he bends over and stands up quickly, he feels lightheaded and dizzy. Following surgery, he was "off work physically for about 12 months"[42] but continued, as best he could, to perform administrative duties for his company.

(h) Mr Hoysted's past medical health was excellent.

(i) Mr Hoysted smoked occasionally when having a beer.

(j) Mr Hoysted is fully independent in his activities of daily living.

[42] Reply at page 2

76. On examination, Dr O'Sullivan observed, amongst other things, that Mr Hoysted was quite bright; was alert; had good speech; demonstrated no cognitive impairment; cranial nerves were normal; fundi showed no evidence of raised intracranial pressure; visual fields were normal; upper and lower limbs demonstrated normal tone, power, coordination and symmetrical reflexes; plantar responses were flexor; no sensory loss; was unsteady walking heel to toe; general examination was unremarkable; and blood pressure of 130/89.

77. Dr O'Sullivan's provided the following diagnosis:

> "The diagnosis is multiple intracranial aneurysms namely the rupture of a right pericallosal aneurysm causing a subarachnoid haemorrhage and un [sic] unruptured right middle cerebral artery aneurysm both of which have been clipped. There is a smaller right middle cerebral artery aneurysm."[43]

78. There were no radiological studies for Dr O'Sullivan to review. However, the documentation provided to him made it clear that there had been successful clipping of both aneurysms.

79. In relation to the question of causation, Dr O'Sullivan opined that Mr Hoysted's injury to his brain was not due to his employment duties and provided the following reasoning:

> "… these were asymptomatic aneurysms and the right pericallosal aneurysm would have ruptured at the time when he developed the explosive headache as described. These aneurysms are congenital in nature and do not relate to the work situation."[44]

80. In relation to the question of fitness for work, Dr O'Sullivan opined as follows:

> "He is the director or owner of the demolition company but he is finding it difficult to perform his normal duties because of the effects of these major neurosurgical procedures. Therefore, although he can manage the company he is not fit to perform the heavy duties that would be required for a person who is involved in demolition."[45]

81. Dr O'Sullivan also opined that Mr Hoysted would be able to work a full working week provided he was not involved in any major physical activity due to the presence of his other aneurysms. Further, Mr Hoysted's incapacity for work is related to the major neurological procedures due to the subarachnoid haemorrhage, the ruptured aneurysms and the fact that he has undergone two major neurosurgical procedures. However, none of this was work-related.

82. In his supplementary report dated 17 August 2017, Dr O'Sullivan acknowledged having read the investigation report of QuantumCorp dated 10 May 2017, wherein it was reported that the temperature at the relevant location on 12 February 2010 was recorded is 29.1°C. Dr O'Sullivan explained that the sudden very hot sensation in the head together with an imminent sensation of explosion and massive headache without warning, was typical of a subarachnoid haemorrhage.

83. Dr O'Sullivan noted that in his statement dated 3 May 2017, Mr Hoysted spoke to Dr Han during a regular check-up about whether the ruptured aneurysm was work-related; and that Dr Han was adamant that it was so related. Accordingly, Dr O'Sullivan believed it very important to obtain a report from Dr Han, Neurosurgeon regarding the relationship between the ruptured aneurysm and Mr Hoysted's work situation "because in my experience I would have to say that it would not be related to work."[46]

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[43] Reply at page 3 at [3]
[44] Reply at page 4 at [4.1]
[45] Reply at page 4 at [5.1]
[46] Reply at page 7

84. Dr O'Sullivan did not consider that the heat of the day would have predisposed Mr Hoysted to suffer the ruptured aneurysm. Mr Hoysted had multiple intracranial aneurysms which were congenital in nature and was fortunate to have survived the rupture. Dr O'Sullivan did not believe that a temperature of 29°C would have given rise to increasing the risk of stroke injury.

85. Dr O'Sullivan did not consider that a stressful situation increased the risk of a worker suffering a stroke injury as diagnosed. He explained his reasoning in the following terms:

> "The reason behind that is that patients will often have a ruptured cerebral aneurysm even while sitting quietly at home and not doing anything. These are congenital aneurysms which may rupture at any stage in a person's life."[47]

86. Dr O'Sullivan opined that Mr Hoysted smoking 30 cigarettes a day could have been a factor or contributor as far as the aneurysm rupture was concerned because of the effect of nicotine on cerebral blood vessels.

SUBMISSIONS

87. The parties made oral submissions at the arbitration hearing which were sound recorded. The sound recording is available to the parties.

The respondent's submissions

88. The respondent's submissions, through its counsel, Ms Hogan, may be summarised as follows:

    (a) Mr Hoysted has pleaded injury as a frank injury and as such, the relevant sections are section 4 and section 9A of the 1987 Act.

    (b) Mr Hoysted relies on the report of Associate Professor Fearnside. Significantly, the history on which Associate Professor Fearnside proceeds to provide an opinion is incorrect and is not made out on Mr Hoysted's own evidence.

    (c) Associate Professor Fearnside took a history from Mr Hoysted performing heavy manual work on a hot summer's day on the date of the alleged injury. Mr Hoysted's evidentiary statement dated 8 October 2018 suggested that his role on the day was of a supervisory nature. This was consistent with the statement he provided to an investigator dated 3 May 2017, when he stated that for most of the morning, he was supervising the loading of trucks that were removing demolition material from the site.

    (d) Mr Hoysted's statements did not disclose that he was performing heavy manual work on 12 February 2010 but, rather, he was organising and supervising the work. It is important because Associate Professor Fearnside provides an opinion on the basis that Mr Hoysted was performing heavy manual work on 12 February 2010.

    (e) Associate Professor Fearnside did not have copies of any clinical records from St Vincent's Hospital, Melbourne and Albury Base Hospital and stated that the clinical records from the latter hospital would be helpful.

[47] Reply at page 7 at [2]

(f) Associate Professor Fearnside opined that on the balance of probabilities, it was likely that the nature and conditions of Mr Hoysted's work on 12 February 2010 was a substantial contributing factor to an aneurysm rupture and that the physical work he was performing could raise his blood pressure and cause the aneurysm to rupture. Mr Hoysted's own evidence was that he was not performing heavy manual work on 12 February 2010.

(g) Associate Professor Fearnside provided an opinion on an incorrect history and without relevant documentation. Therefore, the opinion of Associate Professor Fearnside should not be accepted because he has proceeded on an entirely incorrect history.

(h) There was nothing in the amended ARD which referred to Mr Hoysted working in direct sunlight.

(i) There was reference to Mr Hoysted's anxiety and depression in the material but there is no expert opinion as to its cause and whether it is related to the particular incident.

(j) There is evidence of Mr Hoysted being under the care of Mr Han, the neurosurgeon in Melbourne. Mr Han's clinical notes are not in evidence. There is no report from Mr Han in evidence. The absence of Mr Han's clinical notes or a report from him is particularly important because in his statement dated 3 May 2017 to an investigator, Mr Hoysted stated that Mr Han was adamant that the matter was work-related, in that, both the physical and mental stressors at the time were the major contributing factors to the onset of his injury. In the absence of a report from Mr Han, little weight can be given to Mr Hoysted's statements about the former's opinion in this regard. Mr Han was the treating specialist and one would expect something from him.

(k) In his statement dated 8 October 2018, Mr Hoysted stated that he consulted with his treating neurosurgeon on a regular basis to monitor his condition. However, there is no evidence from the treating neurosurgeon.

(l) In relation to the issue of capacity, Associate Professor Fearnside stated that Mr Hoysted continued his work as the proprietor and owner of his company and that he had considerable difficulty focusing on complex projects. Mr Hoysted advised him that there were symptoms of stress and anxiety. There is no evidence of incapacity or wage loss.

(m) There was an alleged frank incident on 12 February 2010 where there was a subarachnoid haemorrhage.

(n) Associate Professor Fearnside opined that Mr Hoysted was fit to continue work in the demolition industry but had a limited capacity in respect of physical activity. Further, the opinion is expressed some four years after the closed period during which weekly benefits are claimed. There is no evidence in relation to Mr Hoysted's capacity during the period of weekly benefits claimed.

(o) There was no evidence which detailed Mr Hoysted's pre-injury earnings, that is, some evidence of earnings in 2009. In the absence of such evidence, no wage loss can be determined.

(p) There was no contemporaneous evidence in relation to capacity.

(q) Mr Hoysted's Albury Base Hospital clinical notes referred to him smoking 30 cigarettes a day and drinking alcohol on a daily basis.

(r) Mr Hoysted's duties with the respondent prior to injury were not heavy in nature. His statement dated 8 October 2018 described his duties as including marketing, client liaison, demolition planning, staff management and training, supervision, demolition, asbestos removal and machine operation. There was no evidence as to how such duties were divided up. There was no evidence as to why he could not perform those duties during the period of weekly benefits claimed. Mr Hoysted stated that his current role was mostly supervisory and there was no evidence as to why he could not have performed those duties during the period of weekly benefits claimed.

(s) Dr O'Sullivan proceeded to provide an opinion on a correct history. Dr O'Sullivan took a history that, on 12 February 2010 at about 2.00 pm, Mr Hoysted was supervising the loading of salvage material onto a semi-trailer, when his head suddenly felt very hot; felt hot all over his body and experienced an explosive headache.

(t) Dr O'Sullivan noted that Mr Hoysted recovered from the original surgery, being a craniotomy and clipping of the right pericallosal aneurysm and then underwent elective surgery of the other right cerebral artery aneurysm in June 2010.

(u) Dr O'Sullivan noted that Mr Hoysted was struggling to cope due to anxiety and depression when his stress levels built up. There was no evidence that Mr Hoysted's alleged anxiety and depression was related to the incident on 12 February 2010.

(v) Dr O'Sullivan opined that he did not consider that Mr Hoysted sustained an injury to his brain due to his employment duties. Dr O'Sullivan took the view that Mr Hoysted's aneurysms were congenital in nature and not related to his work situation.

(w) Dr O'Sullivan opined that Mr Hoysted was not fit to perform the heavy duties required in demolition work and that he could work a full working week provided he did not perform any heavy physical activity.

(x) The evidence of Dr O'Sullivan should be preferred over that of Associate Professor Fearnside because he proceeded on the correct history.

(y) Dr O'Sullivan's report dated 17 August 2017 relates to section 9B of the 1987 Act issue, which is not relevant to a pre-2012 amending Act injury. However, he does address the heat issue which is raised in the amended ARD. Even though applying the section 9B test, he opined that heat would not have caused Mr Hoysted's injury. He also opined that stress would not have caused the injury and that the injury could have occurred in any event outside employment. Dr O'Sullivan addressed the fact that Mr Hoysted smoked 30 cigarettes a day and opined that it could have been a factor as far as the aneurysm rupture was concerned due to the effect of nicotine on cerebral blood vessels.

(z) There may be a finding that Mr Hoysted suffered an injury in the course of his employment. However, the real difficulty for Mr Hoysted is section 9A of the 1987 Act. There was evidence from Dr O'Sullivan to suggest that Mr Hoysted's injury would have happened in any event.

Mr Hoysted's submissions

89. Mr Hoysted's submissions, through his counsel, Mr Hickey, may be summarised as follows:

(a) The claim is a narrow, albeit complex one.

(b) The claim that is made is of a frank injury in the course of employment of which employment was a substantial contributing factor: sections 4(a) and 9A of the 1987 Act.

(c) *NSW Police Force v Gurnhill*[48] (*Gurnhill*) and *Zickar v MGH Plastic Industries Pty Ltd*[49] (*Zickar*) and numerous other cases talk about the fact that injuries, be it disease or frank, are not mutually exclusive. If an injury definition fits within both disease or frank injury, then it is appropriate to run the case as a frank injury. That is what has occurred in Mr Hoysted's case.

(d) When a frank injury is alleged, there must be a sudden identifiable physiological change. In Mr Hoysted's case, quite clearly, there was an aneurysm which was a sudden identifiable physiological change to the body and as such, brings his claim within section 4(a) of the 1987 Act. It clearly occurred in the course of his employment in the temporal sense. It also arises out of his employment. One would be satisfied that employment was a substantial contributing factor and to the injury itself.

(e) Mr Hoysted runs his own company and he is employed by that company in demolition and asbestos removal. It is patently clear that, when one has regard to both of Mr Hoysted's statements, his work involved physical labour. The fact that he is the principal on the worksite does not absolve him of the requirement to 'get his hands dirty'. Mr Hoysted was using machines, demolishing structures and undertaking such similar work in the course of his employment. A common sense approach has to be taken with respect to Mr Hoysted's statement and the histories he has provided. The reality is that the work involved physical labour at work sites, where he got involved in the physical aspects of the work. Suggesting that Mr Hoysted was merely sitting on the sidelines overseeing work is a completely unrealistic characterisation of how workers, like Mr Hoysted perform their roles. It was contained in the evidence and in any event, it is something which an arbitrator can take judicial notice of in this specialist jurisdiction.

(f) The history recorded by Associate Professor Fearnside is in no way inconsistent with the history recorded in Mr Holroyd's statements. The evidence of history to doctors is evidence of fact: *Guthrie v Spence*[50] (*Guthrie*). The history taken by Associate Professor Fearnside was consistent with the remainder of the evidence.

(g) In his statement dated 8 October 2018, Mr Holroyd described that his work with the respondent was as manager, which included marketing; client liaison; demolition planning; staff management and training; supervision; asbestos removal and machine operation. He typically worked between 10 and 14 hours per day.

[48] *NSW Police Force v Gurnhill* [2014] NSWWCCPD 12
[49] *Zickar v MGH Plastic Industries Pty Ltd* [1996] HCA 31; 187 CLR 310
[50] *Guthrie v Spence* [2009] NSWCA 369 at [75]

(h) In his statement dated 8 October 2018, he described the circumstances of the injury on 12 February 2010 at [21]-[26]. It is quite clear that Mr Hoysted performed a number of roles in his work, including those which were of a physical nature, as well as a supervisory role. Typical of someone running a small business in this regional area.

(i) The issue in this case is sections 4 and 9A of the 1987 Act. It seems to be accepted that the injury occurred, that is, there was an onset of symptoms and that those symptoms related to an aneurysm. The question is was it as a result of work, in the sense that it was a substantial contributing factor. The questions are: what the history was; how that history applied to the circumstances of this case; and what was the medical evidence.

(j) Mr Hoysted's statement dated 3 May 2017 was given to an investigator arranged by the respondent and was included in the Quantumcorp report. It was consistent with his later statement and the history provided to Associate Professor Fearnside.

(k) One would be satisfied, having regard to the evidence, that Mr Hoysted was engaged in advising, demolition work, the removal of materials and refuse across the worksite in the lead-up to him suffering the symptoms which occurred on 12 February 2010. There is no inconsistency in the evidence. Picking apart Mr Hoysted's statement and focussing on his supervisory duties is an artificial approach.

(l) Following 12 February 2012, Mr Hoysted was admitted to hospital; subsequently underwent a number of surgeries; and was off work for approximately 12 months following the injury.

(m) Mr Hoysted told the respondent's insurer, through its investigator at [40] that it was not until he spoke to his treating neurosurgeon that he was told that a workers compensation claim should be lodged. In relation to the inference the respondent says should be drawn in relation to the absence of a report from Mr Han, at its highest point, the statement that Mr Han advised him to lodge such a claim, does not assist Mr Holroyd but does not support the drawing of an adverse inference.

(n) A direction for production was issued to Mr Han and no documents were produced. Mr Han produced two Certificates of Capacity (Reply at pages 38 and 39) confirming that the aneurysm was work-related. Mr Hoysted stated to the respondent's investigator that Mr Han had told him a claim should be lodged. Dr O'Sullivan referred to this statement and in his second report noted that he thought it very important to obtain a report from Mr Han regarding the relationship between the ruptured aneurysm and Mr Hoysted's work situation. So, rather than drawing an adverse inference against Mr Hoysted, the respondent's insurer should have taken steps at that stage to obtain a report from Mr Han. Perhaps an adverse inference should be drawn against the insurer that such a report would not have assisted its case. Associate Professor Fearnside supports Mr Hoysted's case. Accordingly, Mr Hoysted should not have any adverse inferences draw against him due to the absence of material from Mr Han.

(o) Associate Professor Fearnside confirmed the history provided by Mr Hoysted and provided a description of the incident as recounted by him. The history is consistent with the history in Mr Hoysted's statements. He was performing heavy work on a hot day. He was supervising and getting involved in the work. He was under pressure because it was the last day of the project and things needed to be done. It was exactly what one would expect him to do, namely, 'jump in and get involved and lead by example'. Whilst doing this work on 12 February 2010, he experienced the onset of a headache. Such history is consistent throughout the evidence.

(p) Associate Professor Fearnside opined that, on the balance of probabilities, it was likely that the nature and conditions of Mr Hoysted's work on 12 February 2010 was a substantial contributing factor to the aneurysm rupture. He stated that cerebral aneurysms are developmental abnormalities and are well recorded to rupture causing subarachnoid haemorrhage. There are a number of comorbid trigger factors of which hypertension is one. There was no recorded history of hypertension. However, the physical work Mr Holroyd was performing could raise his blood pressure and cause the aneurysm to rupture. Such opinion is of sufficient support to the case put by Mr Hoysted. That is, the rupture of the aneurysm was caused by the work.

(q) Dr O'Sullivan took a history of Mr Hoysted feeling hot and unwell. Dr O'Sullivan did not engage with the type of work Mr Hoysted was doing. He did not consider Mr Hoysted to have sustained injury to his brain due to his employment duties because he had asymptomatic aneurysms in the right pericallosal aneurysm ruptured at the time when he developed the explosive headache. Dr O'Sullivan did not engage with the rupture or with the type of work performed by Mr Hoysted. He should have.

(r) Dr O'Sullivan then provided a supplementary report, having read the Quantumcorp investigation report. In this report, he did refer briefly to Mr Hoysted organising and supervising loading of salvage material onto a semi-trailer. There was still not enough engagement with Mr Hoysted's work and what was going on throughout the day. There was no analysis of the work being performed. Dr O'Sullivan stated that, in his experience, he would have to say that the ruptured aneurysm was not work-related. However, he does not explain what he means when he refers to 'work-related' or 'work situation'. He suggested that it was very important to obtain a report from Mr Han. He did not formally reject Mr Han's alleged opinion that it was work-related. Dr O'Sullivan did not consider that the heat of the day would have predisposed Mr Hoysted to suffer the injury. Mr Hoysted does not submit that the heat of the day predisposed him to suffer the injury. Dr O'Sullivan dismissed stress as increasing the risk of a type of injury suffered by Mr Hoysted. He opined that it was conceivable that smoking 30 cigarettes a day could have been a factor as far as the aneurysm rupture was concerned due to the effect of nicotine on cerebral blood vessels.

(s) Associate Professor Fearnside's opinion is more convincing than that of Dr O'Sullivan.

(t) A common sense causation approach should be taken in regard to the provisions of section 9A of the 1987 Act. Section 9A(2)(a), (b), (c), (d) and (e) are highly relevant in this case. When one looks at the whole of the evidence and the evidence of Associate Professor Fearnside, it is clear that section 9A would be satisfied.

(u) In relation to the issue of capacity, there was evidence of Mr Hoysted's pre-injury earnings. The applicant's Wages Schedule annexes letters from the respondent and the 2010 tax return. Dr O'Sullivan and Associate Professor Fearnside opined that Mr Hoysted has a permanent incapacity restricted to supervisory work. There were two certificates from the treating neurosurgeon, Mr Han. Mr Hoysted still has an incapacity and is endeavouring to push on with his work as best he can. There is ample evidence that he had a significant incapacity following the accident. There is evidence of his pre and post-injury earnings in the letters from his employer and his taxation returns.

(v) Mr Hoysted should not be punished because the respondent's insurer rejected his claim and he did not proceed to seek monthly Certificates of Capacity. He should not be punished because he tried to do the right thing and continue to earn a living as best he could with his medical restrictions.

(w) There should be a finding of injury; that employment was a substantial contributing factor; that such injury resulted in an incapacity and an entitlement to weekly benefits as reflected in Mr Hoysted's Wages Schedule and the contents of Mr Hoysted's evidentiary statement.

The respondent's submissions in reply

90. The respondent's submissions in reply may be summarised as follows:

(a) In relation to the submission on the inference to be drawn, it is not for the insurer to obtain a report from Mr Han to make Mr Hoysted's case, particularly in circumstances where Mr Hoysted, in his own statement, made a reference to an allegedly favourable conversation with Mr Han.

(b) In relation to Mr Hoysted's statements, they do not go as high as he would have them go. We are being asked to draw inferences of the work Mr Hoysted was doing on that day.

(c) In relation to the criticism of Dr O'Sullivan's evidence, the doctor did deal with what Mr Hoysted was doing on the particular day and at the particular time when he experienced the severe headache.

(d) In relation to Mr Han's two certificates, they did not go as far as opining that Mr Hoysted suffered a work injury. The certificates said that there was an aneurysm rupture at work. That does not satisfy section 9A factors. On the second certificate, there was reference to work-related stress. There was nothing on those certificates which addressed the issues in question and they certainly did not say that work was causative of the condition.

(e) In relation to capacity, there is simply not enough evidence to enable a calculation of the comparable earnings and the PIAWE. Caution should be exercised in relation to the letters from the respondent annexed to the Wages Schedule in the absence of a 2009 tax return. The person who signed off on the letters appears to be in some way related to Mr Hoysted through the sharing of a surname.

The respondent's written submissions

91. The respondent's written submissions in compliance with direction 3 dated 6 May 2019 are contained in the Commission's file and may be summarised as follows:

(a) Mr Hoysted's clinical records produced by Albury Base Hospital and St Vincent's Hospital, Melbourne support the respondent's case that Mr Hoysted did not sustain an injury arising out of or in the course of his employment with respondent and to which such employment was a substantial contributing factor.

(b) The treatment provided to Mr Hoysted at St Vincent's Hospital, Melbourne related wholly to the clipping of aneurysms and did not involve treatment of haemorrhage or rupture of an aneurysm.

(c) Investigations conducted initially at Albury Base Hospital and then St Vincent's Hospital, Melbourne did not identify a haemorrhage or rupture but did note such as possible in circumstances in which there was too long a period between the relevant rupture and the investigation. The expert evidence in this case is that there was such a rupture based on Mr Hoysted's reported symptoms.

(d) The only reference to a causal connection between Mr Hoysted's employment with the respondent and a rupture of an aneurysm was contained in the St Vincent's Hospital notes commencing from 13 December 2016, where it was recorded:

> "Been to Slater & Gordon wants to claim WC."

A history was taken consistent with Mr Hoysted's current claim almost seven years after the alleged incident of injury. No opinion was expressed.

(e) The Commission ought to draw an inference that the absence of a report from Mr Hoysted's treating neurosurgeon at St Vincent's Hospital would not have assisted his case.

(f) On 29 February 2012, Mr Hoysted attended Albury Base Hospital and complained of symptoms consistent with those experienced in February 2010. Again, no rupture of an aneurysm was identified.

(g) Any symptoms on 29 February 2012 could not have been as a result of the rupture occurring in February 2010 but, instead, as a result of Mr Hoysted's congenital aneurysms not associated with his employment.

Mr Hoysted's written submissions

92. Mr Hoysted's written submissions in breach of direction 3 dated 28 May 2019, were not lodged until 19 June 2019. The written submissions are contained in the Commission's file and may be summarised as follows:

(a) No adverse inference should be drawn against the applicant for not providing any submissions in relation to the additional late material attached to the respondent's Application to Admit Late Documents dated 13 May 2019 (the additional late material). The additional late material did not give rise to any matters that required submissions over and above those provided at the hearing of the substantive claim.

(b) The respondent's submission that the additional late material supported the contention that the applicant had not sustained an injury arising out of or in the course of employment, in that, there was a distinction between the clipping of an aneurysm and the treatment of a haemorrhage or rupture of an aneurysm, should be rejected out of hand. The respondent's additional written submissions fell foul of my interlocutory determination on 6 May 2019.

FINDINGS AND REASONS

93. I have carefully considered the evidence and the oral submissions made by the parties.

94. I do not draw any adverse inference against Mr Hoysted for not providing any submissions in relation to the additional late material attached to the respondent's Application to Admit Late Documents dated 13 May 2019 and accept his submission in that regard.

95. The relevant legislation and legal principles are outlined below.

96. Mr Hoysted, through his counsel, made it clear that he did not rely on the disease provisions in section 4 of the 1987 Act.

97. Accordingly, the relevant part of section 4 of the 1987 Act provides:

> "In this Act:
>
> 'injury':
>
> (a) means personal injury arising out of or in the course of employment, …"

98. The onus of establishing injury falls upon Mr Hoysted and the standard of proof is on the balance of probabilities, meaning that I must be satisfied to a degree of actual persuasion or affirmative satisfaction: *Department of Education and Training v Ireland*[51] (*Ireland*) and *Nguyen v Cosmopolitan Homes*[52] (*Nguyen*).

99. The issue of causation must be based and determined on the facts in each case. Until recently, the accepted view regarding causation was set out in *Kooragang Cement Pty Ltd v Bates*[53] (*Kooragang*). In *Kooragang*, in perhaps the most commonly cited passage on causation, Kirby P said:

> "The result of the cases is that each case where causation is in issue in a workers compensation claim, must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from', is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent death or injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a common sense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation."[54]

100. The High Court of Australia (the High Court), in *Comcare v Martin*[55] (*Martin*), raised some concerns about the *Kooragang* common sense evaluation of the causal chain test. *Martin* involved the definition of injury under section 5A in the *Safety, Rehabilitation and Compensation Act 1988* (the SRC Act). The High Court's conclusion commences with a caution concerning the use of the "common sense" test:

> "Causation in a legal context is always purposive. The application of a causal term in a statutory provision is always to be determined by reference to the statutory text construed and applied in its statutory context in a manner which best effects its statutory purpose. It has been said more than once in this Court that it is doubtful whether there is any 'common sense' approach to causation which can provide a useful, still less universal, legal norm. Nevertheless, the majority in the Full Court construed the phrase 'as a result of' in s 5A(1) as importing a 'common sense' notion of causation. That construction, with respect, did not adequately interrogate the statutory text, context and purpose.[56]

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[51] *Department of Education and Training v Ireland* [2008] NSWWCCPD 134
[52] *Nguyen v Cosmopolitan Homes* [2008] NSWCA 246
[53] *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796
[54] *Kooragang Cement Pty Ltd v Bates* (1994) 10 NSWCCR 796 at 810
[55] *Comcare v Martin* [2016] HCA 43
[56] *Comcare v Martin* [2016] HCA at [42]

101. As I understand it, when referring to applying "common sense", Kirby, P in *Kooragang* was not suggesting that it be applied "at large" or that issues were to be determined by "common sense" alone but by a careful analysis of the evidence. Therefore, the legislation must be interpreted by reference to the terms of the statute and its context in a fashion that best effects its purpose. Such a concept is not new. Sections 4(b), 9A and 11A of the 1987 Act contain specific requirements and the provisions need to be interpreted using standard principles of interpretation. This does not mean that the common sense approach has no place in the application of the legislation to the facts of the case.

102. In order to establish that a "personal injury" has been suffered, Mr Hoysted must establish, on the balance of probabilities, that there has been a definite or distinct "physiological change" or "physiological disturbance" in the brain for the worse which, if not sudden, is at least, identifiable: *Kennedy Cleaning Services Pty Ltd v Petkoska*[57] (*Kennedy*) and *Military Rehabilitation and Compensation Commission v May*[58] (*May*). The word "injury" refers to both the event and the pathology arising from it: *Lyons v Master Builders Association of NSW Pty Ltd*[59] (*Lyons*). While pain may be indicative of such physiological change, it is not itself a "personal injury".

103. *Castro v State Transit Authority*[60] (*Castro*) provides a useful review of the authorities and makes it clear that what is required to constitute "injury" is a "sudden or identifiable pathological change". In *Castro*, a temporary physiological change in the body's functioning (atrial fibrillation: irregular rhythm of the heart), without pathological change, did not constitute injury.

104. *Zickar* highlighted that a worker can rely on injury simpliciter despite the existence of a disease. The High Court held that the presence of a disease did not preclude reliance upon that event as a personal injury. The terms "personal injury" and "disease" are not mutually exclusive categories. A sudden identifiable physiological (pathological) change to the body brought about by an internal or an external event can be a personal injury and the fact that the change is connected to an underlying disease process does not prevent the injury being a personal injury: *North Coast Area Health Service v Felstead*.[61]

105. I now turn to the application of the relevant legislation and the legal principles referred to above to the available evidence in this matter, bearing in mind that Mr Hoysted bears the onus of establishing his case on the balance of probabilities.

106. Mr Hoysted's unchallenged evidence is that towards mid-afternoon on 12 February 2010, he suddenly experienced a really hot feeling in his head and felt as though it was going to explode; a massive headache; a hot feeling in his whole body and a sense of instability. On the following Sunday, he experienced uncontrollable shaking in his left arm. He reported to Dr Fearnside that he also experienced shaking in his left leg but to a lesser extent.

107. On 17 February 2010, some five days following Mr Hoysted's incident at work, Dr Mullins' MRI scan report conclusion was that of a left anterior cerebral artery aneurysm and two small right middle cerebral artery aneurysms. The report did not refer to a subarachnoid haemorrhage.

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[57] *Kennedy Cleaning Services Pty Ltd v Petkoska* [2000] HCA 45
[58] *Military Rehabilitation and Compensation Commission v May* [2016] HCA 19
[59] *Lyons v Master Builders Association of NSW Pty Ltd* (2003) 25NSWCCR 496
[60] *Castro v State Transit Authority* [2000] NSWCC 12; (2000) 19 NSWCCR 496
[61] *North Coast Area Health Service v Felstead* [2011] NSWWCCPD 51 at [77]

108. In his CT brain scan report dated 12 March 2010, Dr Lott referred to the purpose of the scan as being to exclude subarachnoid haemorrhage, noting that there were three known cerebral aneurysms and that Mr Hoysted was presenting with headache. Dr Lott concluded that there was no subarachnoid haemorrhage identified but noted that there was a potential for a false negative CT finding in patients with subarachnoid bleed. As Dr Galloway later explained in his CT brain scan report dated 6 May 2010, a normal CT scan does not exclude subarachnoid haemorrhage if performed more than 12 hours after the onset of symptoms.

109. In his operation report dated 24 March 2010, Dr Thien noted that Mr Hoysted presented with unruptured aneurysms and an angiogram which had defined a pericallosal aneurysm, a right middle cerebral aneurysm and a supposedly left middle cerebral artery aneurysm.

110. Mr Han's Certificates of Capacity dated 28 March 2017 and 12 September 2017 provided a description of injury/disease as subarachnoid haemorrhage and a diagnosis of ruptured cerebral aneurysm.

111. Dr O'Sullivan diagnosed multiple intracranial aneurysms, namely, a ruptured right pericallosal aneurysm causing a subarachnoid haemorrhage and an unruptured right middle cerebral artery aneurysm and a smaller unruptured right middle cerebral artery aneurysm. Dr O'Sullivan opined that these were asymptomatic congenital aneurysms and that the right pericallosal aneurysm would have ruptured at the time when Mr Hoysted developed the explosive headache he described.

112. Associate Professor Fearnside stated that it was unclear as to the basis on which the diagnosis of subarachnoid haemorrhage was made. However, he opined that the history of sudden onset of very severe headache was consistent with a diagnosis and that it was probable that Mr Hoysted had sustained a focal seizure the following day when he experienced uncontrollable shaking of his left arm and left leg. The latter symptoms were also consistent with a subarachnoid haemorrhage.

113. I am satisfied on the evidence that, towards mid-afternoon on 12 February 2010, Mr Hoysted suffered a rupture of a congenital right pericallosal aneurysm causing a subarachnoid haemorrhage.

114. On the basis of the principles espoused in *Zickar*, I am satisfied that, despite the fact that Mr Hoysted's rupture of a right pericallosal aneurysm causing a subarachnoid haemorrhage could be characterised as a disease which was present as at 12 February 2010, it did not preclude reliance on the definite or distinct physiological change or disturbance in his brain in the form of a rupture of the said aneurysm on that date as a "personal injury" within the meaning of section 4(a) of the 1987 Act. The terms "personal injury" and "disease" are not mutually exclusive categories. A sudden identifiable physiological (pathological) change to the body brought about by an internal or an external event can be a personal injury and the fact that the change is connected to an underlying disease process does not prevent the injury being a personal injury.

115. Accordingly, I find that Mr Hoysted sustained a personal injury in the form of a rupture of a congenital right pericallosal aneurysm causing a subarachnoid haemorrhage in the course of his employment with the respondent on 12 February 2010 within the meaning of section 4(a) of the 1987 Act.

116. The next issue to be determined is whether Mr Hoysted's employment was a substantial contributing factor to the injury within the meaning of section 9A of the 1987 Act.

117. Liability for an employer to pay compensation pursuant to section 9 of the 1987 Act is limited by the requirement under section 9A that employment is a substantial contributing factor to the injury.

118. The respondent submitted that employment was not a substantial contributing factor to the injury.

119. The background to section 9A of the 1987 Act and relevant legal principles are outlined below.

120. Section 9A of the 1987 Act was introduced shortly after the High Court's decision in *Zickar*. Mr Zickar, a 21-year-old worker, collapsed at work after suffering a rupture of a cerebral aneurysm, which resulted in severe brain damage. The aneurysm was a congenital weakness and had no relationship to work. At first instance, Mr Zickar was successful in his claim for workers compensation (Thompson J in the Compensation Court). A majority of the Court of Appeal overturned the decision. Mr Zickar was given special leave to appeal to the High Court.

121. The High Court, by majority (4:3), allowed Mr Zickar's appeal. The case turned on the construction of "injury" as defined in section 4 of the 1987 Act. The Court held that the rupture may be a "personal injury", despite the existence of a disease (the aneurism). The presence of a disease did not preclude reliance upon that event as a personal injury (per Toohey, McHugh and Gaudron JJ at 335). Their Honours agreed with the observations of Murphy J in *Accident Compensation Commission v McIntosh* [1991] 2 VR 253 where his Honour said:

> "If the rupture is due to blood pressure, arteriosclerosis, arteriovenous malformation, or any other congenital or diagnostic aetiology, it is nonetheless a rupture - something quite distinct from the defect, disorder or morbid condition, which enables it to occur." (at 262)

Kirby J, in a separate judgment, said:

> "It is enough that the 'injury' took place in the course of employment. It is not necessary to show that it arose 'out of' such employment." (at 352)

122. If a worker receives a "personal injury" in the course of employment, he/she will have satisfied the definition of an injury in section 4. All that is required in the case of a "personal injury" is a temporal connection with the employment and not a causal connection. Subject to specific limitations on liability, a worker would then be entitled to various benefits under the workers compensation scheme.

123. In introducing the *WorkCover Legislation Amendment Bill* 1996 in Parliament, which included the proposed section 9A, the then NSW Attorney-General and Minister for Industrial Relations, the Hon Jeff Shaw QC MLC, said section 9A was to limit compensation coverage to situations where employment is a substantial contributing factor to the worker's injury, which is in line with the primary objective of compensating workers who suffer injuries that have a proper link with the workplace, rather than those whose injuries have only a remote or tenuous connection with work.

124. Section 9A of the 1987 Act is reproduced below in full:

> "(1) No compensation is payable under this Act in respect of an injury (other than a disease injury) unless the employment concerned was a substantial contributing factor to the injury.
>
> **Note:** In the case of a disease injury, the worker's employment must be the main contributing factor. See section 4.

(2) The following are examples of matters to be taken into account for the purposes of determining whether a worker's employment was a substantial contributing factor to an injury (but this subsection does not limit the kinds of matters that can be taken into account for the purposes of such a determination):

(a) the time and place of the injury,

(b) the nature of the work performed and the particular tasks of that work,

(c) the duration of the employment,

(d) the probability that the injury or a similar injury would have happened anyway, at about the same time or at the same stage of the worker's life, if he or she had not been at work or had not worked in that employment,

(e) the worker's state of health before the injury and the existence of any hereditary risks,

(f) the worker's lifestyle and his or her activities outside the workplace.

(3) A worker's employment is not to be regarded as a substantial contributing factor to a worker's injury merely because of either or both of the following:

(a) the injury arose out of or in the course of, or arose both out of and in the course of, the worker's employment,

(b) the worker's incapacity for work, loss as referred to in Division 4 of Part 3, need for medical or related treatment, hospital treatment, ambulance service or workplace rehabilitation service as referred to in Division 3 of Part 3, or the worker's death, resulted from the injury.

(4) This section does not apply in respect of an injury to which section 10, 11 or 12 applies."

125. Section 9A(2) of the 1987 Act provides a non-exhaustive list of matters to be taken into account in determining whether employment was a substantial contributing factor.

126. Whether employment is a substantial contributing factor to an injury is a question of fact and is a matter of impression and degree: *Dayton v Coles Supermarkets Pty Limited*[62] (*Dayton*); *McMahon v Lagana*[63] (*McMahon*) to be decided after a consideration of all the evidence. See also *WorkCover Authority of NSW v Walsh.*[64]

127. Under section 9A of the 1987 Act, employment must be a substantial contributing factor to the injury, not to the incapacity, the need for treatment or the loss: *Rootsey v Tiger Nominees Pty Ltd*.[65]

128. What is required is the careful analysis of what the worker was doing at the time of the injury and the strength of the causal link between the employment concerned and the injury. Other causative factors may be present. The probability that the injury could have occurred anyway or at the same stage of the worker's life must be considered, as must the lifestyle of the worker. The determination is an evaluative one, leaving a broad area for the personal judgment of the decision maker: *Hevi Lift (PNG) Limited v Everington*[66] (*Hevi Lift*).

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[62] *Dayton v Coles Supermarkets Pty Limited* [2001] NSWCA 153 at [29]
[63] *McMahon v Lagana* [2004] NSWCA 164 at [32]
[64] *WorkCover Authority of NSW v Walsh* [2004] NSWCA 186
[65] *Rootsey v Tiger Nominees Pty Ltd* (2002) 23 NSWCCR 725
[66] *Hevi Lift (PNG) Limited v Everington* [2005] NSWCA 42

129. In *Badawi* a full bench of the NSW Court of Appeal reviewed the provisions of section 9A of the 1987 Act. *Mercer v ANZ Banking Group*[67] was not followed. Allsop P, Beazley and McColl JJA, (Handley AJA dissenting) held that the phrase "substantial contributing factor" in section 9A involved a causative element and said:

> "81. Causation is a fact-laden conclusion which the courts have been told must be based on common sense: *March v Stramare (E & MH) Pty Limited* [1991] HCA 12; 171 CLR 506; and *Nunan.* It is not possible and indeed would be incorrect, therefore, to lay down a principle which can be applied unbendingly to all cases. Nonetheless, we consider the following observations should be made.
>
> 82. First, and perhaps most importantly, the word 'substantial', must be given effect. It is a word of ordinary English meaning. It is a word of evaluative concept… The words of the statute should be adhered to: 'a substantial contributing factor'. The 'proper link' in the legislative context was a causal connection expressed by the words 'a substantial contributing factor', meaning one that was real and of substance. Given the conflict in the existing authority (*Mercer*, *Bulga* and *Dayton*), we think it important to clarify this issue.
>
> 83. Secondly, we respectfully disagree with Mason P's observation (notwithstanding that Beazley JA agreed with it at the time) that the causal requirement in s 9A is less stringent than that in s 9 (as read with s 4). If it were, there would be no point in s 9A extending to both limbs of the definition of injury. We have explained the source of Mason P's views in the comments in *Favelle Mort* on a different phrase ('a contributing factor'). As Mason P observed in *Mercer*, there is an incongruity in having a double causation test, one in s 9 and one in s 9A. However, the legislature, in seeking to remedy the lack of causal connection with employment that the second limb of s 4 has, that is, 'in the course of employment', must be taken to have seen the need to ensure that the connection of the employment with the injury under either limb was 'substantial'. Had it restricted the s 9A requirement to 'the course of employment' limb, it is possible that the required connection with the employment would have been different, depending upon which limb of s 4 was engaged. Notwithstanding that the legislative consequence is cumbersome to a degree, the intention is clear…
>
> 85. It should be said, however, that there may be circumstances where the factors considered necessary and sufficient to satisfy the test 'arising out of employment' for the purposes of s 9, are sufficient to satisfy the test in s 9A. Whether that is so will depend on the facts. Both are factual questions. The question under each section is differently expressed and must be considered separately. It is not sufficient to find that an injury arose out of 'employment' and to thereby be able to conclude that the employment concerned was a 'substantial contributing factor'. Such a reasoning process is expressly proscribed by s 9A(3)."

130. Allsop P, Beazley and McColl JJA, (Handley AJA dissenting) held that in determining whether a worker's employment was a substantial contributing factor, the matters specified in section 9A(2) must be taken into account to the extent that they are relevant. Their Honours considered that section 9A(2)(b) directed attention to the nature of the work performed and the particular tasks of that work and not to what the employee was doing at the actual time of the injury.

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[67] *Mercer v ANZ Banking Group* [2000] NSWCA 138

131. Basten JA concurred with the decision of the majority, considering that the causal test imposed by section 9A was more stringent than that imposed by section 4. His Honour observed that if the conduct out of which the injury arose occurred in the course of employment and was the effective cause of the injury, absent misconduct on the part of the employee, the only conclusion reasonably open is that the employment was a substantial contributing factor to the injury. His Honour also said that the words "employment concerned" in section 9A(1) reinforced the view that it is the work activity in which the worker was actually engaged at the time of injury that is relevant and that the ultimate question is whether the activity or task was a "substantial contributing factor to an injury" bearing in mind that the concept is exegeted in sections 9A(2) and 9A(3).

132. Mr Hoysted bears the onus of establishing that employment was a substantial contributing factor. A finding that Mr Hoysted sustained a personal injury arising out of or in the course of his employment with the respondent on 12 February 2010 within the meaning of section 4(a) of the 1987 Act of itself is not sufficient to satisfy the requirements of section 9A of the 1987 Act: section 9A(3)(a). As discussed above, section 9A also involves a causative element and the causal connection must be "real and of substance".

133. The only evidence of the events of 12 February 2010 leading up to Mr Hoysted's ruptured aneurysm and resultant subarachnoid haemorrhage is to be found in his evidentiary statements and the histories he provided to Dr O'Sullivan and Associate Professor Fearnside some 7 to 8 years following the incident at the Thurgoona Plaza redevelopment site. Whilst I have no reason to doubt Mr Hoysted's credibility, I must be cautious about the reliability of his evidence. Mr Hoysted's evidentiary statement dated 3 May 2017 was provided to an investigator engaged by CGU, more than seven years after the incident. Mr Hoysted's evidentiary statement dated 8 October 2018 was completed with the assistance of his lawyer, more than 8.5 years after the incident.

134. In *Onassis and Calogeropoulos v Vergottis*[68], Lord Pearce said of documentary evidence:

> "It is a truism, often used in accident cases, that with every day that passes the memory becomes fainter and the imagination becomes more active. For that reason, a witness, however honest, rarely persuades a Judge that his present recollection is preferable to that which was taken down in writing immediately after the accident occurred. Therefore, contemporary documents are always of the utmost importance."

135. More recently, in *Watson v Foxman*,[69] the McLelland CJ in Equity said:

> "… Human memory of what was said in a conversation is fallible for a variety of reasons, and ordinarily the degree of fallibility increases with the passage of time, particularly where disputes or litigation intervene, and the processes of memory are overlaid, often subconsciously, by perceptions or self-interest as well as conscious consideration of what should have been said or could have been said. All too often what is actually remembered is little more than an impression from which the plausible details are then, again often subconsciously, constructed. All of this is a matter of human experience."[70]

136. In his evidentiary statement dated 3 May 2017, Mr Hoysted stated that, on 12 February 2010, he was working for the respondent at the Thurgoona Plaza redevelopment site. He commenced his duties at 7.00 am. It was a hot day. During the course of most of the morning, he was supervising the loading of trucks that were removing demolition material

[68] *Onassis and Calogeropoulos v Vergottis* [1968] 2 Lloyd's Rep 403 at 431
[69] *Watson v Foxman* (1995) 49 NSWLR 315
[70] *Watson v Foxman* (1995) 49 NSWLR 315 at 319

from a portion of the site they had previously demolished. He did not refer to having undertaken any heavy manual work as he had reported to Associate Professor Fearnside. In his evidentiary statement dated 8 October 2018, Mr Hoysted stated that on 12 February 2010, he was working at the Thurgoona Plaza redevelopment site supervising the removal of demolition refuse that his team had previously demolished, as well as assisting with the cartage and loading. He did not provide any detail as to what the assisting with the cartage and loading involved. However, it presumably involved some physical activity on his part but its seems that he was not involved in such activity, if at all, for any prolonged period of time as he stated that he had been supervising the loading of trucks for most of the morning. I agree with the respondent's submission in relation to Mr Hoysted's statements, in that, I am being asked to draw inferences of the physical work Mr Hoysted was performing on 12 February 2010.

137. The Albury Base Hospital clinical records did not provide much by way of contemporaneous assistance as to the events of 12 February 2010 or causation. The first entry in the clinical records referred to an entry on 15 February 2010 and recorded that Mr Hoysted attended the Emergency Department and consulted Dr Chaffey. Mr Hoysted's presenting problem was recorded as headache. The nursing assessment data recorded four days of left side head numbness with associated left arm pins and needles. He had undergone a CT scan and was awaiting its result. Mr Hoysted expressed concern that he was having a stroke. The records recorded nil by way of allergies or medication. In relation to other personal details, it was recorded that he smoked 30 cigarettes per day; drank three stubbies per day; lived alone; and owned his own demolition company. On examination it was noted, amongst other things, that he had pressured speech and occasionally made inappropriate comments. It was recommended that he undergo an MRI brain scan.

138. The St Vincent's Hospital, Melbourne clinical records did not provide anything by way of contemporaneous assistance as to the events of 12 February 2010 or causation. The clinical records commenced with an entry on 10 March 2010. The last entry related to Mr Hoysted's neurosurgery clinic visit on 28 March 2017. Included in the clinical records were the notes relating to Mr Hoysted's admission prior to and following the surgical procedures on 24 March 2010 and 2 June 2010 and the neurosurgery clinic follow-up visits and investigative procedures thereafter.

139. Histories in medical records are often used to attack the credit of a worker. Reference is made either to a failure to mention relevant matters, or a description in a medical record which is different to what the worker now says in evidence. Care should be taken when considering such evidence, not to place too much weight on the clinical notes of treating doctors, given their primary concern with treatment. Experience demonstrates that busy doctors sometimes misunderstand, omit or incorrectly record histories of accidents or complaints by a patient, particularly in circumstances where their concern is with the treatment or impact of an obvious frank injury: *Davis v Council of the City of Wagga Wagga*[71]; and applied in *King v Collins*[72] and *Mastronardi v State of New South Wales*[73].

140. The caution referred to above was confirmed by Roche DP in *Winter v NSW Police Force*[74] as follows:

> "It is important to remember that clinical notes are rarely (if ever) a complete record of the exchange between a patient and a busy general practitioner. For this reason, they must be treated with some care (*Nominal Defendant v Clancy* [2007] NSWCA 349; *Davis v Council of the City of Wagga Wagga* [2004] NSWCA 34; *King v Collins* [2007] NSWCA 122 at [34-36])."[75]

[71] *Davis v Council of the City of Wagga Wagga* [2004] NSWCA 34
[72] *King v Collins* [2007] NSWCA 122
[73] *Mastronardi v State of New South Wales* [2009] NSWCA 270
[74] *Winter v NSW Police Force* [2010] NSWCCPD 12
[75] *Winter v NSW Police Force* [2010] NSWCCPD at [183]

141. I acknowledge that caution must be taken when relying upon clinical records. Especially, in Mr Hoysted's case where the medical and other hospital staff were focussed on a serious and potentially life-threatening medical emergency. I have exercised caution in this regard and considered all the evidence.

142. Mr Hoysted's treating neurosurgeon, Mr Han, issued two Certificates of Capacity dated 28 March 2017 and 12 September 2017.

143. Mr Han's Certificate of Capacity dated 28 March 2017 provided a description of injury/disease as subarachnoid haemorrhage and a diagnosis of ruptured cerebral aneurysm. The descriptor requesting other details was left blank. The tick boxes relating to the question as to whether the injury/disease was consistent with Mr Hoysted's description of cause were left blank. The treatment was described as craniotomies for clipping two aneurysms. Under the heading "work restrictions", appeared the words: "Aneurysm rupture at work. Unfit for work since 10/3/2010". [76] The latter certification of unfitness for work was clearly incorrect as Mr Hoysted, on his own evidence, had returned to work for the respondent on restricted duties. The Certificate of Capacity provides no opinion as to causation. It simply certifies, some seven years after the event, that Mr Hoysted suffered an aneurysm rupture at work.

144. Mr Han's Certificate of Capacity dated 12 September 2017 provided a description of injury/disease as subarachnoid haemorrhage and a diagnosis of ruptured cerebral aneurysm. However, on this occasion, the descriptor referring to other details had the words "work-related stress" included in the appropriate answer box. The treatment was described as craniotomies for clipping two aneurysms. Under the heading "work restrictions", appeared the words: "Aneurysm rupture at work. Unfit for work since 10/3/2010".[77] Again, the latter certification of unfitness for work was clearly incorrect as Mr Hoysted, on his own evidence, had returned to work for the respondent on restricted duties.

145. Mr Han only referred to work-related stress in the Certificate of Capacity dated 12 September 2017. Contrary to Mr Hoysted's understanding, expressed in his statement dated 3 May 2017, Mr Han did not refer to both the physical and mental stressors of Mr Hoysted's work at the time as having been the major contributing factors in the onset of the injury. Accordingly, I can give no weight to Mr Hoysted's said understanding in this regard. Further, there is no evidence from Mr Han explaining what he understood to be the work-related stress he was referring to and one would not expect such detail to be provided in a Certificate of Capacity.

146. There is no report by Mr Han in evidence. I am aware that a Direction for Production was issued to Mr Han and that no documents were produced. I make no adverse inferences against either party for the absence of documents or reports from Mr Han in the material before me.

147. The parties' submissions on the section 9A issue focussed mainly on the differing opinions of the respective forensic medical specialists, Dr O'Sullivan and Associate Professor Fearnside.

148. Dr O'Sullivan took a history from Mr Hoysted. Such history did not include that Mr Hoysted had been performing heavy manual work on 12 February 2010. The history taken did refer to 12 February 2010 having been a hot day and that Mr Hoysted believed he had suffered heatstroke. This is consistent with Mr Hoysted's statement dated 3 May 2017, to which Dr O'Sullivan had access.

[76] Reply page 38
[77] Reply page 39

149. In relation to the question of causation, Dr O'Sullivan opined that Mr Hoysted's ruptured aneurysm was not due to his employment duties because he had asymptomatic aneurysms and the right pericallosal aneurysm would have ruptured at the time when he developed the explosive headache as described. These aneurysms were congenital in nature and did not relate his work situation.

150. Dr O'Sullivan did not consider that the heat of the day on 12 February 2010 would have predisposed Mr Hoysted to suffer the ruptured aneurysm. Mr Hoysted had multiple intracranial aneurysms which were congenital in nature and he was fortunate to have survived the rupture. Dr O'Sullivan did not believe that a temperature of 29°C would have given rise to increasing the risk of stroke injury.

151. Dr O'Sullivan did not consider that a stressful situation increased the risk of a ruptured aneurysm. He observed that in his experience, patients will often have a ruptured cerebral aneurysm even while sitting quietly at home and not doing anything. These are congenital aneurysms which may rupture at any stage in a person's life.

152. Dr O'Sullivan also opined that Mr Hoysted smoking 30 cigarettes a day could have been a factor or contributor as far as the aneurysm rupture was concerned because of the effect of nicotine on cerebral blood vessels.

153. Associate Professor Fearnside took a history from Mr Hoysted that, prior to the aneurysm rupturing on 12 February 2010, Mr Hoysted and co-workers were demolishing the Thurgoona Plaza. He was performing heavy manual work on a hot summer's day. The work included demolishing parts of the Plaza and loading the demolished material onto a truck. Mr Hoysted was working under considerable pressure to finish the demolition as it was the last scheduled day of the project, so that the builders could commence their work. He was also working under considerable financial pressure because he was unable to pay workers' wages that week. The history that Mr Hoysted provided to Associate Professor Fearnside relating to having performed heavy manual work was not entirely consistent with his own evidentiary statements that that he had been supervising the loading of trucks for most of the morning. In neither statement did he refer to that fact that he was performing heavy manual labour prior to the incident. The closest reference to labouring work is the reference in his second statement that he assisted with cartage and loading. The history recorded by Associate Professor Fearnside was that, at about 2.00 pm on 12 February 2010, after having performed heavy manual work, he felt the sudden onset of a burning pain in his head and felt unstable on his feet, followed by a severe headache. That is not consistent with Mr Hoysted's evidentiary statements, as he stated that he had been had been supervising the loading of trucks for most of the morning.

154. Associate Professor Fearnside based his opinion on causation on the fact that Mr Hoysted had performed heavy manual work up to the time of the incident. I am not satisfied that Associate Professor Fearnside had a complete history of the relevant events leading up to Mr Hoysted's ruptured aneurysm. There were no clinical records from the Albury Base Hospital or St Vincent's Hospital, Melbourne made available to Associate Professor Fearnside. Associate Professor Fearnside indicated that a review of the clinical records, particularly from Albury Base Hospital, would be helpful. It does not appear that he was provided with those clinical records and if he was, there is no supplementary report in evidence dealing with the same.

155. In relation to the issue of causation, Associate Professor Fearnside opined, on the balance of probabilities, that it was likely that the nature and conditions of Mr Hoysted's work on 12 February 2010 was a substantial contributing factor to the aneurysm rupture. There were a number of comorbid trigger factors. One was hypertension but there was no recorded history of hypertension. However, he then opined that the physical work Mr Hoysted was performing *could* have raised his blood pressure and caused the aneurysm rupture.

156. I am not persuaded by Associate Professor Fearnside's conclusion as to causation, namely, that the physical work Mr Hoysted was performing *could* have raised his blood pressure and caused the aneurysm rupture. I prefer the opinion of Dr O'Sullivan, who had available to him the Albury Base Hospital and St Vincent's Hospital, Melbourne clinical records and a correct history of the events of 12 February 2010 and provided reasoning in support of his conclusions.

157. I now turn to consider the matters referred to in section 9A(2) of the 1987 Act and make the following observations and findings:

(a) "The time and place of the injury":

The unchallenged evidence is that Mr Hoysted suffered a rupture of a congenital right pericallosal aneurysm causing a subarachnoid haemorrhage at or about 2.00 pm on 12 February 2010 in the course of his employment with the respondent at the Thurgoona Plaza redevelopment site whilst standing on the ground and supervising the use of an excavator to load the salvage material onto a truck.

(b) "The nature of the work performed and the particular tasks of that work":

I find that on 12 February 2010, Mr Hoysted was working at the Thurgoona Plaza redevelopment site, in the main, supervising the removal of demolition refuse that his team had previously demolished. There is no evidence that he was involved in heavy manual work on that day up to the time of the incident as recorded by Associate Professor Fearnside. At the time of the subject incident, he was supervising the use of an excavator to load the salvage material onto a truck.

Preferring the evidence of Dr O'Sullivan over that of Associate Professor Fearnside, I find that, on the evidence, the nature of the work performed, and the particular tasks of that work were not causative of the rupture of the congenital right pericallosal aneurysm resulting in a subarachnoid haemorrhage, in that, there was no connection with Mr Hoysted's employment which was "real and of substance". Similarly, I find that that the heat of the day on 12 February 2010 would not have predisposed Mr Hoysted to suffer the ruptured aneurysm. I also find that hypertension caused by Mr Hoysted's alleged stressful situation at the time increased the risk of a ruptured aneurysm.

(c) "The duration of the employment":

The unchallenged evidence is that Mr Hoysted had been the sole director and an employee of his demolition company since 2007. He engaged the services of casual employees or contractors as required to carry out demolition jobs. Mr Hoysted's duties included all the company's administrative duties; client liaison; marketing; planning and carrying out of demolition; planning and carrying out asbestos removal; staff hiring and supervision; training and machine operation. He usually worked 12 to 14 hours each day, during which time his duties could include physical activity, mechanical maintenance and administration. Following the incident, he did not return to work for the respondent until December 2010 and thereafter, worked six to eight hours per day, three days per week in mainly supervisory duties.

(d) "The probability that the injury or a similar injury would have happened anyway, at about the same time or at the same stage of the worker's life, if he or she had not been at work or had not worked in that employment":

I accept Dr O'Sullivan's evidence that, in his experience, patients will often have a ruptured cerebral aneurysm even while sitting quietly at home and not doing anything and that such congenital aneurysms may rupture at any stage in a person's life.

(e) "The worker's state of health before the injury and the existence of any hereditary risks":

The unchallenged evidence is that Mr Hoysted was in reasonably good health prior to 12 February 2010. However, I accept Dr O'Sullivan's evidence that Mr Hoysted had three asymptomatic aneurysms prior to 12 February 2010, namely, a right pericallosal aneurysm, a right middle cerebral artery aneurysm and a smaller right middle cerebral artery aneurysm, which could have ruptured at any stage.

(f) "The worker's lifestyle and his or her activities outside the workplace":

There was little evidence relating to Mr Hoysted's life style or activities outside the workplace. The Albury Base Hospital clinical records recorded that he smoked 30 cigarettes per day; drank three stubbies per day; lived alone; and owned his own demolition company. I accept Dr O'Sullivan's evidence that Mr Hoysted smoking 30 cigarettes a day could have been a factor or contributor as far as the aneurysm rupture was concerned because of the effect of nicotine on cerebral blood vessels.

158. On the evidence, the strength of the causal link between the employment concerned and the injury in this case is extremely weak. After a careful analysis of the evidence and after a consideration of the authorities cited above, I find that there was not a causal relationship between the injury and the work Mr Hoysted was required to do, that is, there was no connection with his employment which was "real and of substance". Accordingly, I am not satisfied that Mr Hoysted's employment was a substantial contributing factor to his injury within the meaning of section 9A of the 1987 Act.

SUMMARY

159. Mr Hoysted sustained a personal injury in the form of a rupture of a congenital right pericallosal aneurysm causing a subarachnoid haemorrhage in the course of his employment with the respondent on 12 February 2010 within the meaning of section 4(a) of the 1987 Act.

160. Mr Hoysted's employment with the respondent was not a substantial contributing factor to the injury within the meaning of section 9A of the 1987 Act.

161. Award for the respondent.