WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3657/14**
Applicant: **Geoffrey Peter Hallmann**
Respondent: **National Mutual Life Association of Australasia**
Date of Determination: **24 July 2019**
Citation: **[2019] NSWWCC 258**

The Commission determines:

1. Matter remitted to the Registrar for referral to Approved Medical Specialist/s for assessment of permanent impairment under the Table of Disabilities of the following losses:

    (a) permanent brain damage;
    (b) permanent impairment of the neck;
    (c) permanent impairment of the back;
    (d) permanent impairment of the pelvis;
    (e) loss of right arm at or above the elbow;
    (f) loss of left arm at or above the elbow;
    (g) loss of right leg at or above the knee;
    (h) loss of left leg at or above the knee;
    (i) permanent loss of bowel function;
    (j) loss of sexual organs;
    (k) loss of sight of both eyes;
    (l) loss of hearing of both ears;
    (m) loss of power of speech;
    (n) loss of sense of smell

2. Registrar to forward the documents as set out in the attached schedule, subject to agreement of the applicant and the respondent, to the Approved Medical Specialist/s.

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

Grahame Edwards
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 OF GRAHAME EDWARDS, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Geoffrey Peter Hallmann (the applicant) commenced the current proceedings in the Commission against National Mutual Life Association of Australasia Limited (the respondent) upon the filing of an Application to Resolve a Dispute (the Application) on 18 July 2014. Mr Hallmann is a self-represented litigant.

2. Mr Hallman claimed weekly payments of compensation from 16 March 2004; interest on the weekly payments of compensation; medical and related treatment expenses pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act), including the cost of vitro fertilisation (IVF), domestic assistance pursuant to s 60AA of the 1987 Act; and lump sum compensation pursuant to ss 66 and 67 of the 1987 Act for losses or impairments under the Table of Disabilities as particularised at Part 5.6 of the Application as a result of suffering injury (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) with persisting Fibromyalgia (FM)) arising out of or in the course of employment with the respondent with the injury deemed to have happened on 29 November 1996.

3. The respondent filed its Reply to the Application (the Reply) on 8 August 2014.

4. The respondent accepts Mr Hallman suffers with ME/CFS with persisting FM as a result of injury deemed to have happened on 29 November 1996.

5. The insurance scheme agent (CGU Workers Compensation (NSW) Limited (CGU)) for the respondent issued a number of notices pursuant to s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) as follows:

    (a) liability for injury declined – dated 20 January 2005[1];

    (b) liability for injury declined – dated 30 October 2006[2];

    (c) claim for reimbursement of medical expenses – dated 11 April 2011[3];

    (d) lump sum compensation claim – dated 23 August 2011[4];

    (e) claim for additional weekly payments for dependent spouse – dated 1 September 2011[5];

    (f) claim for proposed investigations for cardiac symptoms and blood tests/pathology for cholesterol, HOL, LAL, TG, glucose, Homocysteine – dated 29 September 2011[6]

    (g) claim for proposed investigations for cardiac treatment, blood tests for cholesterol, HOL, LAL, TG, glucose, Homocysteine – dated 13 October 2011[7];

    (h) section 60AA claim for domestic assistance – washing, cleaning, lawn mowing and gardening services – dated 12 July 2012[8];

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[1] Reply – p 1506
[2] supra – p 1508
[3] supra – p 1510 - 1512
[4] supra – pp 1513 - 1515
[5] supra – pp 1516 – 1519
[6] Application – pp 509 - 511
[7] Reply – pp 1520 – 1522
[8] supra – pp 1523 – 1557

(i) section 60 claim – IVF treatment – dated 14 January 2013[9];

(j) permanent impairment claim – dated 30 January 2013[10], and

(k) claim for car travel, car hire, car parking, costs, flights, food, accommodation – dated 12 March 2014[11].

6. The respondent in Part 3 of the Reply raised a number of matters, including seeking leave of the Commission pursuant to s 289A(4) of the 1998, to supplement the multiple s 74 notices, and to raise additional grounds of dispute.

7. Interlocutory applications and discretionary orders were made at telephone conferences held between Mr Hallmann and legal representatives for the respondent in the interests of CGU, and also at the conciliation conference/arbitration hearings.

8. Conciliation conferences/arbitration hearings were listed for the following dates:

(a) 26 November 2014;
(b) 28 January 2015, and
(c) 17, 18 and 19 March 2015

9. The claims for weekly payments of compensation and interest were the subject of a conciliation conference on 26 November 2014, which are referred to in paragraphs 31 to 46, and 67 to 69.

10. The respondent's application pursuant to s 289A(4) of the 1998 Act putting liability in issue for permanent impairment of the pelvis, loss of power of speech and loss of sense of smell as a result of injury was dealt with at the arbitration hearing on 28 January 2015.

11. Leave was granted to Mr Hallmann at the arbitration hearing on 28 January 2015 to correctly plead at Part 5 of the Application the losses in respect of which he claims lump sum compensation:

(a) permanent impairment of the pelvis;
(b) loss of power of speech, and
(c) loss of sense of smell.

12. Leave was granted to the respondent pursuant to s 289A(4) of the 1998 Act at the arbitration hearing on 28 January 2015[12] to dispute liability in respect of Mr Hallmann's claim that he suffers with conditions or symptoms of his pelvis, speech and smell as a result of his ME/CFS with persisting FM.

13. The respondent disputes Mr Hallmann suffers with permanent impairment or losses as a result of the ME/CFS with persisting FM of the:

(a) pelvis;
(b) speech, and
(c) smell.

[9] Application – pp 523 – 524
[10] supra – pp – 527 – 529
[11] Reply – pp 1610 – 1621
[12] Transcript – 28/1/2015 – pp 69 – 72

Previous proceedings

14. Mr Hallmann has been involved in multiple proceedings in the Commission prior to the filing of the current Application.

15. Matter No. 12737/02 (claim for weekly payments and medical expenses).

16. Matter No. 18609/03 (claim for weekly payments of compensation and medical expenses). The matter resolved upon the issuing of a Certificate of Determination – Consent Orders by Arbitrator Douglas dated 16 March 2004[13] ordering the respondent to pay weekly payments of compensation for the period 11 October 1996 to 11 April 1997 with an award for the respondent in respect of the applicant's claim for weekly payments of compensation thereafter to date and continuing. The respondent was also ordered to pay medical expenses pursuant to s 60 of the 1987 Act.

17. Matter No. 14934/04 (claim for medical expenses). The matter resolved upon the issuing of a Certificate of Determination by Arbitrator Theobald dated 11 March 2005[14].

18. On 1 April 2005, the Commission issued an Amended Certificate of Determination in Matter No. 14934/04.

19. Matter No. 2475/04 (claims for medical and related treatment expenses (sports skins) and interest). The matter resolved on the issuing of a Certificate of Determination by Arbitrator Theobald dated 23 May 2005[15].

20. Matter No. 15446/05 (claims for weekly payments of compensation and medical expenses). The matter resolved on the issuing of a Certificate of Determination – Consent Orders by Arbitrator Theobald dated 2 December 2005[16].

21. Matter No. 9588/05 (claims for lump sum compensation).

22. Mr Hallmann was assessed by Approved Medical Specialists in their fields of speciality in respect of the losses claimed under the Table of Disabilities.

23. Mr Hallmann appealed to the Medical Appeal Panel pursuant to s 327 of the 1998 Act against the assessment of the Approved Medical Specialists.

24. On 9 November 2006, the Appeal Panel issued its statement of reasons[17].

25. Matter No. 1498/07 (application by CGU for termination of liability for the payments of medical and related treatment expenses). The matter was finalised on the issuing of a Certificate of Determination by Arbitrator Bell on 1 June 2007[18] (CGU's application dismissed, and Certificate of Determination issued in Matter No 14934/04 rescinded pursuant to s 350(3) of the 1998 Act and replaced with an order that the respondent pay the applicant's s 60 expenses).

26. Proceedings were commenced in the Supreme Court in case number 30171/06, seeking a writ of certiorari quashing the medical certificate issued by the Medical Appeal Panel in Matter No. 9588/05.

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[13] Application – p 1455
[14] supra – p 1456
[15] supra – p 1462
[16] supra – p 1467
[17] supra – pp 1468 – 1474
[18] supra – p 1475

27. On 4 June 2007, the Court made consent orders setting aside the Medical Assessment Certificate issued by the Medical Appeal Panel and remitting the matter to the Registrar of the Commission for referral to a newly constituted appeal panel[19].

28. On 9 October 2007, the newly constituted Medical Appeal Panel appointed by the Registrar issued its statement of reasons and Medical Assessment Certificate in Matter No. 9588/05[20].

29. On 30 October 2007, the Registrar issued a Certificate of Determination in Matter No. 9588/05[21] ordering the respondent to pay the applicant lump sum compensation pursuant to s 66 of the 1987 Act in respect of the following losses as a result of injury on 29 November 1996:

    (a) 1% permanent loss of efficient use of the right arm at or above the elbow;

    (b) 1% permanent loss of efficient use of the left arm at or above the elbow;

    (c) 1% permanent loss of efficient use of the right leg at or above the knee;

    (d) 1% permanent loss of efficient use of the left leg at or above the knee;

    (e) 1% permanent impairment of the neck;

    (f) 1% permanent impairment of the back;

    (g) 10% permanent loss of efficient use of the sexual organs, and

    (h) 0% permanent impairment of the bowel, visual system, hearing and brain.

30. Matter No. 5494/13 (claim for weekly payments of compensation, interest, medical and related treatment expenses and lump sum compensation).

31. On 6 June 2014, the Commission issued a Certificate of Determination and the statement of reasons of Arbitrator Stanton[22] in Matter No. 5494/13, dismissing the proceedings pursuant to s 354(7) of the 1998 Act.

Current proceedings

Background

32. From 22 January 2010, there was extensive correspondence in the form of emails and letters, and telephone conversations between Mr Hallmann and CGU as to his entitlement to weekly payments of compensation on the basis the Consent Orders issued on 16 March 2004 entering an award in favour of the respondent could not be maintained in law.

33. Correspondence from CGU indicates it sought documentary evidence from Mr Hallmann as to his actual earnings, and his claims for dependency of de-facto partners and dependent children at various times.

34. On 29 December 2010[23], CGU wrote to Mr Hallmann advising that payments for weekly benefits for the period 1 April 2004 to 26 August 2010 had been processed, and that the amount of $75,829.73 was paid to Centrelink for their charge in respect of that period.

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[19] Application – p 1481
[20] supra – p 1484
[21] supra – p 1494
[22] Reply – pp 1496 – 1505
[23] Application – p 1991

35. On 14 July 2011[24], CGU wrote to Mr Hallmann advising that lump sums for arrears of weekly payments of compensation had been paid to him on 10 December 2010, 29 December 2010, 8 April 2011 and 19 May 2011, amounting to $161,940 with a deduction of $86,612.16 to Centrelink.

36. On 14 August 2014, a telephone conference held with Mr Hallmann and Mr Lichaa, solicitor representing the interests of CGU, established that the claim for weekly payments from 16 March 2004 related to the calculation of Mr Hallmann's probable earnings if he remained in the same or some comparable employment uninjured as well as the issue of dependency, and the periods of dependency.

37. Mr Hallman was receiving weekly payments of compensation on a voluntary basis from CGU at the time of the resolution of this part of his claim at the conciliation conference on 26 November 2014.

38. The respondent was represented at the conciliation conference by Mr Barter of counsel, instructed by Mr Underwood, solicitor, in the interests of CGU.

39. The claim for additional weekly payments of compensation, the amount of the probable earnings as calculated by the respondent, the claim pursuant to s 38 of the 1987 Act, and dependants and the periods of dependency were discussed between Mr Hallmann, Mr Barter and Mr Underwood over several hours before resolution was reached as to the amount of the probable earnings, entitlement to payments pursuant to s 38 of the 1987 Act, and the dependency claim.

40. The agreement reached between Mr Hallmann and CGU was reduced to writing, entitled "Short minutes of Order" with an attachment entitled "Schedule A", setting the rates of the additional weekly payments for the period 16 March 2004 to 30 June 2014, totalling $30,000.

41. The parties did not reach agreement as to the interest claimed on the award amount of $30,000.

42. The question of interest on the award was reserved.

43. On 28 November 2014, the Commission issued a Certificate of Determination – Consent Orders, in accordance with the "Short Minutes of Order", noting that the amount of $30,000 as referred to Order No. 2 represented payments in accordance with "Schedule A", and that the question of interest on the award amount, and the other issues in dispute would be dealt with at the further conciliation conference/arbitration hearing on 28 January 2015.

44. At the arbitration hearing on 28 January 2015, Mr Hallmann made an application for the respondent to pay him the sum of $180,000 in interest on the arrears of weekly payments of compensation from 16 March 2004 to 30 June 2014 on the basis of the delayed payment of weekly payments of compensation paid by tranches of lump sums in 2010 and 2011.

45. For reasons given in an ex-tempore decision delivered at the arbitration hearing[25], I found the Commission did not have jurisdiction to determine the claim for interest on the arrears of weekly payments of compensation from 2004 paid in tranches in 2010 and 2011 because there was no evidence to establish that Mr Hallmann had made a claim upon the respondent for interest on the arrears of weekly payments of compensation from 2004.

46. I found the Commission had jurisdiction to determine the claim for interest on the amount of $30,000 for the additional payments of weekly payments of compensation as set out in the Consent Orders issued on 28 November 2014.

[24] Application – pp 2010 – 2012
[25] transcript – 28/1/2015 – pp 2 – 4

47. The Commission issued a Direction dated 28 January 2015 for the parties to file and serve written submissions, in accordance with a time table, on the claim for interest in respect of the amount of $30,000 in satisfaction of the claim for additional payments of compensation for the period 16 March 2004 to 26 November 2014 (incorrectly particularised in the Direction as 29 November 1996 to 26 November 2014).

48. The remaining matters in dispute were listed for further arbitration hearing on 17, 18 and 19 March 2015.

49. On 25 February 2015, Mr Hallman filed his submissions on the question of interest.

50. On 13 March 2015, the respondent filed its submissions in reply.

51. I gave an ex tempore decision at the arbitration hearing on 17 March 2015[26] in relation to the respondent's application made at the arbitration hearing on 28 January 2015 that the reports of the nominated treating specialist, Dr Whiting, should not be admitted into evidence because it was submitted Dr Whiting had become an advocate in Mr Hallman's cause; that he had lost his objectivity and impartially as an expert; that he was not an accredited WorkCover specialist; his reports were in breach of r 14(3) of the Workers Compensation Commission Rules 2011 (2011 Rules) and Practice Direction 3 issued by the Workers Compensation Commission; and that he did not apply any "intellectual rigour" to his reasoning to assess permanent impairment of the pelvis, loss of power of speech and loss of sense of smell.

52. The reports of Dr Whiting were admitted into evidence for reasons I gave in the extempore decision.

53. The respondent made no further application that the reports of the nominated treating doctors, Drs Bird and Watson, should not be admitted into evidence, but made submissions that little or no weight should be given to their opinions because they had become advocates in Mr Hallmann's cause, and their reports were in breach of r 14(3) of the 2011 Rules and Practice Direction 3.

54. While Mr Hallmann attended the arbitration hearings on 17 and 18 March 2015, he was unable to attend the hearing on 19 March 2015 due to the effects of his ME/CFS with persisting FM.

55. The arbitration hearings on 17 and 18 March 2015 were predominately taken up with submissions by the respondent on the disputed issue of whether Mr Hallmann suffers with conditions of his pelvis, speech and smell as a result of the ME/CFS with persisting FM resulting in losses under the Table of Disabilities.

56. The arbitration hearing was adjourned for the purpose of issuing Directions to the parties to provide written submissions on the disputed issues.

57. On 2 April 2015, Mr Hallman filed submissions in reply on the question of interest.

58. On the same date, the Commission issued a Direction to the parties setting a timetable for the filing of submissions on the following:

    (a) conditions of the pelvis, speech and smell as a result of injury (ME/CFS with persisting FM);

    (b) admissibility of the respondent's forensic medical reports (Prof Wakefield and Dr Potter), and

[26] transcript – pp 29 – 36

(c) admissibility of the applicant's medical reports (Drs Bird, Whiting and Watson).

59. On 18 June 2015, the Commission issued a further Direction to the parties setting a new time table for the filing of submissions because of Mr Hallmann's failure to comply with the Direction issued on 2 April 2015.

60. The Direction included notations reminding Mr Hallmann of the provisions of ss 354 and 367 of the 1998 Act, and also Pt 15 r 1 of the 2011 Rules, that submissions were to be relevant to the issues in dispute.

61. Also, Mr Hallman was reminded that the time for filing of further evidence by way of Applications to Admit Late Documents closed when the Commission set the time tables for the filing of submissions.

62. On 21 August 2015, the Commission issued a further Direction to the parties setting a new time table for the filing of submissions because of Mr Hallmann's failure to comply with the Direction issued on 18 June 2015.

63. On 9 August 2016, Mr Hallmann eventually complied with the Direction issued on 21 August 2015 when he filed his submissions on the admissibility of the reports of Prof Wakefield and Drs Potter and Slezak.

64. The Commission granted leave to the respondent to file its submissions by 31 October 2016 because of Mr Hallmann's failure to comply with the Directions issued on 2 April 2015, 18 June 2015 and 21 August 2015.

65. On 26 October 2016, the respondent filed its submissions in reply. No application was made by the respondent for the reports of Drs Bird and Watson to be rejected on the grounds of breaching r 14(3) of the 2011 Rules and Practice Direction 3.

66. On 8 November 2016, Mr Hallmann elected to file further submissions in response to the respondent's submissions dated 26 October 2016 notwithstanding the time for filing further submissions and evidence had closed.

67. On 13 December 2016, the Commission issued my Certificate of Determination and Statement of Reasons to the parties in respect of the following matters:

    (a) interest;

    (b) admissibility of forensic medical reports relied upon by the respondent (Prof Wakefield, Drs Potter and Slezak);

    (c) pelvis, loss of power of speech and loss of sense of smell as a result of injury;

    (d) claim for domestic assistance, and

    (e) medical and related treatment expenses, including IVF treatment, disputed by the respondent upon the issuing of the s 74 notices dated 29 September 2011, 13 October 2011 and 14 January 2013.

68. In respect of the claim for interest, I found the arrears of weekly payments of compensation were not duly made and particularised until the filing of the Application to Admit Late Documents by Mr Hallmann on 8 October 2014.

69. I also found the respondent was unable to distil and understand the ambit of Mr Hallmann's claim for weekly payments of compensation until the filing of the Application to Admit Late documents on 8 October 2014.

70. In the exercise of my discretion pursuant to s 109 of the 1998 Act, I awarded interest on the amount of $30,000 at the Supreme Court rate applicable for the period 8 October 2014 to 26 November 2014.

71. I admitted the forensic medical reports of Prof Wakefield and Drs Potter and Slezak into evidence.

72. In respect of the claim for domestic assistance of washing, cleaning, ironing, lawn mowing, garden and yard maintenance as particularised at Part 5.6 of the Application, I was not satisfied at the time of issuing my Statement of Reasons that Mr Hallmann suffers with 15% whole person impairment to entitle him to domestic assistance[27].

73. No assistance plan was provided in accordance with a care plan established by CGU as required by Guideline 3 of the WorkCover Guidelines for Provision of Domestic Assistance 2004; and also, there was no assessment of whole person impairment in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment*, *4th edition* (the Guidelines), and the *American Medical Association's Guides to the Evaluation of Permanent Impairment, 5th Edition* (AMA5).

74. I reserved the question of Mr Hallmann's entitlement to domestic assistance until assessment of permanent impairment of the body parts as a result of the injury by an Approved Medical Specialist upon determination of the disputed conditions of the pelvis, speech and smell as a result of ME/CFS with persisting Fibromyalgia.

75. In respect of the disputed conditions of the pelvis, loss of power of speech and loss of sense of smell as a result of injury, the matter was remitted pursuant to s 321(1) of the 1998 Act to the Registrar for referral to an Approved Medical Specialist for a non-binding opinion on the following:

> "1. whether the applicant suffers with conditions of the pelvis, loss of power of speech and loss of sense of smell as a result of injury (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome with persisting Fibromyalgia) or whether as a result of consequential conditions resulting from the injury deemed to have happened on 29 November 1996.
>
> 2. whether the following medical and related treatment is reasonably necessary as a result of injury (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome with persisting Fibromyalgia) deemed to have happened on 29 November 1996:
>
> i. Investigations for cardiac symptoms and blood tests/pathology for cholesterol, HOL, LAL, TG, glucose and Homocysteine, and
> ii. IVF treatment relating to the applicant."

76. The Registrar was unable to refer the medical dispute for assessment by an Approved Medical Specialist until finalisation of appeals by Mr Hallmann lodged pursuant to s 352(1) of the 1998 Act to the Commission constituted by a Presidential member in respect of the dispute by the Commission constituted by an Arbitrator.

[27] s 60AA of the 1987 Act

77. On 24 April 2017, President Keating in *Hallmann v The National Mutual Life Association of Australasia Ltd*[28] (*Hallmann No.* 1) dismissed the appeal pursuant to s 354(7A) of the 1998 Act and r 15.8 of the 2011 Rules for the want of due despatch by Mr Hallmann to prosecute the grounds of his appeal in relation to the various interlocutory and discretion orders set out in the Certificate of Determination issued by the Commission on 13 December 2016.

78. On 21 May 2018, Deputy President Wood in *Hallmann v National Mutual Life Association of Australia Limited*[29] (*Hallmann No.* 2) pursuant to r 16.2(12) of the 2011 Rules refused the application for extension of time to file the appeal:

> "Application for extension of time to file the appeal – r 16.2(12) of the Workers Compensation Commission Rules 2011; whether error in terms of referral of a general medical dispute to an Approved Medical Specialist; no error in excluding admission of late evidence after submissions were commenced – *Micallef v ICI Australia Operations Pty Ltd* [2001] NSWCA 274; evidence required to enable an award of interest pursuant to s 109 of the *Workplace Injury Management and Workers Compensation Act 1998*; whether Independent Medical Examiners appointed by the respondent had a conflict of interest; the model litigant policy; decision maker entitled to disregard submissions filed out of time – *Bale v Mills* [2011] NSWCA 226; 81 NSWLR 498; 282 ALR 336"

79. While the application for extension of time to file the appeal was refused, Deputy President Wood discussed and made findings in respect of the 30 grounds of Mr Hallmann's appeal identified as follows:

> "(a) the exclusion of his Application to Admit Late Documents (Issue 1);
>
> (b) the Arbitrator's decisions on interest (Issue 2);
>
> (c) admissibility of medical reports of Professor Wakefield and Dr Potter (Issue 3);
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> (d) consequential loss (Issue 4);
>
> (e) domestic assistance (Issue 5), and
>
> (f) terms of the referral to the AMS (Issue 6)."

80. On 29 May 2018, the Delegate of the Registrar issued an Amended Request for Assessment of General Medical Dispute by Approved Medical Specialist.

81. Dr Loretta Reiter was appointed by the Registrar as the Approved Medical Specialist.

82. The specific questions the Approved Medical Specialist was requested to address were:

> "1. whether the applicant suffers with conditions of the pelvis, loss of power of speech and loss of sense of smell as a result of injury (Myalgic Encephalomyelitis/Chronic Fatigue with persisting Fibromyalgia) or whether as a result of a consequential conditions resulting from the injury deemed to have happened on 29 November 1996.

[28] [2017] NSWWCCPD 14
[29] [2018] NSWWCCPD 20

2. whether the following medical and related treatment is reasonably necessary as a result of injury (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome with persisting Fibromyalgia) deemed to have happened on 29 November 1996:

    (a) investigations for cardiac symptoms and blood tests/pathology for cholesterol, HOL, LAL, TG, glucose, Homocysteine, and

    (b) IVF treatment relating to the applicant and his partner."

83. On 3 July 2018, the Approved Medical Specialist assessed Mr Hallmann.

84. On 19 July 2018, the Approved Medical Specialist issued her Amended Medical Assessment Certificate (Amended MAC).

85. The Approved Medical Specialist answered the specific questions set out in the terms of referral as follows:

    "i. **Whether the applicant suffers with conditions of the pelvis, loss of power of speech and loss of sense of smell as a result of injury (Myalgic Encephalomyelitis/Chronic Fatigue with persisting Fibromyalgia) or whether as a result of a consequential conditions resulting from the injury deemed to have happened on 29 November 1996.** (emphasis in original)

    No. The applicant does NOT suffer with conditions of the pelvis, loss of power of spech and loss of sense of smell as a result of injury (Myalgic Encephalitis/Chronic Fatigue Syndrome with persisting Fibromyalgia) or whether as a result of consequential conditions resulting from the injury deemed to have happened on 29 November 1996.

    ii. whether the following medical and related treatment is reasonably necessary as a result of injury (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome with persisting Fibromyalgia) deemed to have happened on 29 November 1996:

        a. investigations for cardiac symptoms and blood tests/pathology for cholesterol, HOL, LAL, TG, glucose, Homocysteine, and

        b. IVF treatment relating to the applicant and his partner.

        No. The following medical and related treatment is NOT reasonably necessary as a result of injury (Myalgic Encephalitis/Chronic Fatigue Syndrome with persisting Fibromyalgia) deemed to have happened on 29 November 1996:

        c. Investigations for cardiac symptoms and blood tests/pathology for cholesterol, HOL, LAL, TG, Glucose and Homocysteine.

        d. IVF treatment relating to the applicant and his partner."

86. On 30 July 2018, I conducted a telephone conference with Mr Hallmann and Mr Underwood for the purpose of hearing arguments in respect of applications by Mr Hallmann to provide further submissions on the disputed conditions of the pelvis, speech and smell; to re-open his case to adduce further medical evidence; to cross-examine a former employee of CGU and to make oral submissions.

87. To ensure the parties received a timely determination of their dispute, the reasons for the orders set out below were given orally at the telephone conference:

> "The determination of the Commission in this matter is as follows:
>
> 1. Application by the applicant to hold a further arbitration hearing for the purpose of making oral submissions is refused.
>
> 2. Application by the applicant to provide further written submissions on the disputed issues of loss of the pelvis, loss of power of speech and loss of sense of smell as a result of injury deemed to have happened on 29 November 1996 is refused.
>
> 3. Application by the applicant to re-open his case for the purpose of adducing further medical evidence is refused.
>
> 4. Application by the applicant to re-open his case for the purpose of seeking leave to cross-examine a former employee of the respondent's insurance scheme agent is refused.
>
> 5. Direction for written submissions issued to the parties.
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> A sound recording of the reasons given is available to the parties on request.
>
> **NOTATIONS:**
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> 1. The applicant is reminded again that the time for filing of further evidence by way of Application to Admit Late Documents closed when the Commission called for submissions from the parties in accordance with timetables set out in Directions dated 2 April 2015 and 12 (sic – 28) June 2015, and that in exceptional circumstances only will leave be granted to a party to re-open its case.
>
> 2. The applicant has provided six sets of written submissions dated 18 March 2015 (x 4), 10 July 2015 and 17 July 2015 on the disputed issues of loss of pelvis, loss of power of speech and loss of sense of smell as a result of injury deemed to have happened on 29 November 1996.
>
> 3. The applicant has provided two sets of written submissions dated 9 August 2016 (346 pages) and 8 November 2016 (36 pages) on the question of the admissibility of forensic reports relied upon by the respondent into evidence."

88. On 2 August 2018, the Commission issued an Amended Direction following a telephone conference on that date as follows:

> ‘‘1. The applicant is to lodge and serve by 31 August 2018 separate written submissions on the following:
>
> (a) Medical Assessment Certificate issued by the Approved Medical Specialist on 19 July 2018 as to the opinion provided about the disputed losses of the pelvis, loss of power of speech and loss of sense of smell as a result of injury or consequential condition resulting from injury deemed to have happened on 29 November 1996.
>
> (b) whether past and future medical and related treatment expenses, including IVF treatment, as particularised at Part 5.3 of the Application to Resolve a Dispute and in notices issued by the respondent pursuant to section 74 of the *Workplace Injury Management and Workers Compensation Act 1998* dated 29 September 2011, 13 October 2011 and 14 January 2013, are reasonably necessary as a result of injury deemed to have happened on 29 November 1996.
>
> 2. The respondent is to lodge and serve by 30 September 2018 written submissions in reply.
>
> 3. Leave granted to the parties to apply to the Registrar for an extension of time to complete and file written submissions.
>
> 4. At the conclusion of the time allowed for submissions the dispute will be determined ‘on the papers’.”

89. On 31 August 2018, Mr Hallmann filed his submissions (187 pages with eight annexures) on the Amended MAC issued by the Approved Medical Specialist.

90. On 13 November 2018, the respondent filed its submissions (40 pages) in reply on the Amended MAC issued by the AMS.

91. On 18 January 2019, Mr Hallmann filed his submissions (635 pages attaching six annexures) on the issue whether past and future medical and related treatment expenses, including IVF treatment, as particularised at Part 5.3 of the Application and disputed in the notices issued by the respondent pursuant to 74 of the 1998 Act are reasonably necessary as a result of injury.

92. On 24 January 2019, Mr Hallmann filed further submissions (956 pages attaching six annexures) on the s 60 issues.

93. On 10 April 2019, the respondent filed its submissions (8 pages) in reply on the s 60 issues.

94. On 11 April 2019, Mr Hallman filed further submissions (30 pages attaching two annexures) on the s 60 issues.

ISSUES FOR DETERMINATION

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

    (a) Does the applicant suffer with conditions of the pelvis, loss of power of speech and loss of sense of smell as a result of injury (ME/CFS with persisting FM)?

    (b) Are the medical and related treatment expenses (past and future), including IVF treatment, as particularised in Part 5.3 of the Application and disputed in s 74 notices reasonably necessary as a result of injury (ME/CFS with persisting FM) within the meaning of s 60 of the 1987 Act?

PROCEDURE BEFORE THE COMMISSION

96. 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 disputes.

EVIDENCE

Documentary evidence

97. I do not propose to list the voluminous and excessive number of documents filed by the parties, which is a matter of record on the Commission's computerised system.

98. I grant leave to the applicant to file an Application to Admit Late Documents dated 10 July 2015 attaching medical reports and questionnaires completed by the applicant relating to treatment because of the disputed issues as to whether the pelvis, speech and smell are a result of ME/CFS with persisting FM.

FINDINGS AND REASONS

Issue 1 – Does the applicant suffer with conditions of the pelvis, loss of power of speech and loss of sense of smell as a result of injury (ME/CFS with persisting FM) deemed to have happened on 29 November 1996?

99. Mr Hallmann provided written submissions dated 18 March 2015 x 3 described as "Applicant submissions" (the first set of submissions); "Applicant further Submissions" (the second set of submissions) and "Applicant Further (2) submissions" (the third set of submissions) in addition to very short submissions he made at the arbitration hearing on 18 March 2015[30]. Mr Hallmann wished to commence his oral submissions notwithstanding it was 4.50 pm with the intention of completing them the following day. He was unable to attend the arbitration hearing on 19 March 2015 due to his condition of ME/CFS with persisting FM. The respondent had made oral submissions in respect of the alleged conditions and losses at the arbitration hearings on 17 and 18 March 2015.

100. On 2 April 2015, the Commission issued a Direction setting a timetable for the filing of further submissions on the disputed conditions of the pelvis, loss of power of speech and loss of sense of smell (see paragraph 57 above) as well as calling for written submissions on the dispute claim of interest and other evidentiary interlocutory applications.

[30] transcript – 18 March 2015 – pp 65 – 72

101. On 10 July 2015, Mr Hallmann provided further written submissions described as "Applicant submissions in reply on respondent submissions" (the fourth set of submissions).

102. On 17 July 2015, Mr Hallmann provided further written submissions described as "Applicant submissions in reply on respondent submissions" (the fifth set of submissions).

103. The respondent provided its written submissions dated 14 August 2015.

104. Mr Hallmann alleges that as a result of his working conditions with the respondent he suffers with a range of medical conditions. It is not in dispute that Mr Hallmann suffers with ME/CFS with persisting FM arising out of or in the course of employment with the injury deemed to have happened on 29 November 1996.

105. It was common ground between the parties in *Hallmann No. 2* that Mr Hallmann alleges the pelvis, speech and smell are conditions or symptoms of the injury (ME/CFS with persisting FM)[31], rather than consequential conditions resulting from the injury[32]; although he raised the principle of consequential condition resulting from injury by reference to *North Coast Area Health Service v Felstead*[33]; *Australian Traineeship System v Turner*[34]; *Kumar v Royal Comfort Bedding Pty Ltd*[35]; *Bouchmouni v Bakhos Matta t/as Western Red Services*[36] in his first set of submissions.

106. It was also common ground in *Hallmann No. 2* that Mr Hallmann claims the conditions of the pelvis, speech and smell are the result of the injury (ME/CFS with persisting FM) within the meaning of s 4 of the 1987.

Applicant's submissions – written submissions dated 18 March 2015 (x 3)

107. Mr Hallmann submitted the conditions of the pelvis, speech and smell are a result of his injury[37], and that the chain of causation or causal chain between his conditions and the injury is established on the balance of probabilities by the medical evidence of his nominated treating doctors, Drs Bird, Watson and Whiting.

108. Mr Hallmann submitted Drs Bird, Watson and Whiting are experts in the field of ME/CFS with persisting FM.

109. Mr Hallmann submitted Dr Bird has been his treating general practitioner since 2003, and that he has a specific interest in the management and treatment of persons suffering with ME/CFS and FM.

110. Mr Hallmann submitted Dr Whiting, who is a general physician specialising in internal medicine and infectious diseases with experience in pathology and endocrinology, has been his treating specialist since December 2011 for his conditions of ME/CFS with persisting FM; and is an expert in this field of medicine; eminently qualified to provide opinions about the causal link between the ME/CFS with persisting FM and the conditions of his pelvis, speech and smell as a result of the injury.

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[31] *Hallmann v National Mutual Life Association of Australia Limited* [2018] NSWWCCPD 20 at [426

[32] see *Bouchmouni v Bakhos Matta t/as Western Red Services* [2013] NSWWCCPD 4 at [52] – [76] and *Australian Traineeship System v Turner* [2012] NSWWCCPD 4 at [28] – [29] and [61] for a discussion by Roche DP of the difference between an "injury" and a condition that has resulted from the injury.

[33] [2011] NSWWCCPD 51at [84]

[34] [2012] NSWWCCPD at [28] and [29]

[35] [2012] NSWWCCPD 8 at [35]-[49]

[36] [2013] NSWWCCPD 4 at [52]-[76]

[37] *Filippo Alfio Foti v Trazmet Forwork Pty Limited* [2013] NSWWCC 151 at [31]

111. In respect of Dr Watson, who is a consultant in rehabilitation medicine and qualified AMA5 assessor, Mr Hallmann submitted he is eminently qualified to provide opinions about the symptoms and conditions of the pelvis, speech and smell resulting from his ME/CFS with persisting FM.

112. In respect of the pelvis, Mr Hallmann submitted the condition arises from neurological pain and muscle spasms, which are a feature of the ME/CFS but particularly FM.

113. In respect of speech, Mr Hallmann submitted the condition arises from neurocognitive and neurological issues resulting from the ME/CFS.

114. In respect of smell, Mr Hallmann submitted this condition arises from persisting staphylococcus sinus infection as well as sensitivities to various smells (perfumes, petrochemical, pollens etc) resulting from the ME/CFS.

115. Mr Hallmann, in his first set of submissions, set out a table listing the reports of Drs Bird, Watson and Whiting, and other medical providers upon whom he relies, to establish the causal link between his symptoms and the ME/CFS with persisting FM as a result of the injury.

116. Mr Hallman, in his second set of submissions, submitted the onset of the conditions occurred in 1995 and was part of "the cascade of musculoskeletal symptoms that occurred at that time with pain beginning in the hip, then the groin and progressed to the back".

117. Mr Hallmann submitted the pain in the groin was in the pelvic region as recorded upon presentation to Mr Neil Mansen, chiropractor, at his first consultation on 4 November 1996[38]: "a bit of pain in right groin, hip, some back pain & Achilles problems".

118. Mr Hallmann submitted he completed a "new client form" at his first attendance with Mr Mansen, particularising his symptoms as follows:

> "Low Back Pain, Neck Pain, Joint Pain/Stiffness, Walking Problems, General Stiffness, Nervous, Numbness, Stress, Fatigue, Weight Trouble, Coughs, Stuffed Nose, Heartburn, bit of pain in right groin, hip, some back pain & Achilles problems".

119. Mr Hallmann submitted there was a very definite change in symptoms on 29 November 1996 resulting in him stopping work, which he said was the date the "pain hit my groin and back", and that over the weeks through September to November 1996, the pain was in the right Achilles to the right knee, the right groin and the lower back[39].

120. Mr Hallmann submitted Dr Sutherland, independent medical expert qualified by the respondent, assessed him on 17 September 1999, 1 October 1999 and 14 October 2002, reporting on 9 December 2002[40] the following history:

> "By mid-October, he was troubled by pain in his right Achilles tendon, and then developed a pain in the right groin which seemed to radiate to his lower back and down his right leg."

121. Mr Hallmann submitted the symptoms as recorded by Dr Sutherland are consistent with the condition of the pelvis as a result of the ME/CFS but in particular as a symptom of FM.

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[38] Application – p 234 – annexure 22
[39] Applicant's statement dated 7 March 2014 at p 99
[40] Reply – p 18 – 111 at p 27

122. Mr Hallmann submitted he is supported as to the onset of his symptoms in the pelvis region by the history taken by Dr Whiting recorded in his report dated 24 March 2013[41] as follows:

> "…
>
> (ii) Initial focus – Mr Hallman points out that, at the commencement of the injury, the vast majority of doctors he encountered were focused on his back symptoms only (an unusual approach given it began with the right Achilles, then the right knee, right groin, sacrum, for example) He states that they failed to listen/record some of the issues at that time and failed to record his vies that it was work related (and the reasons attached to his belief). For this reason, Mr Hallmann believes a lot of significant information was not recorded and/or reported to the doctors early on in his history. I find this to be fair comment and not unusual in the history of those with ME/CFS. It can take quite some time to obtain a full history and understanding of the condition.
>
> (iii) In accepting this history and the symptoms that were present, I have been provided with significant evidence among Mr Hallmann's medical documents that demonstrates **a clearly recognisable cluster of symptoms** (emphasis in original) at that time. I specifically refer to his patient record, dated 4 November 1996 (some 25 days before he left his employment due to illness), which was completed for his Chiropractor, Dr Neil Mansen. The symptoms recorded on this document are consistent with a diagnosis of ME/CFS. In addition, these documents, a number of other documents produced early 1997 (i.e. blood test and IME Report) pointed to lethargy, muscle spasms, progressive muscle and joint pain and 'bizarre' symptoms (see below). I am therefore very satisfied that the condition existed from at least 4 November q996 especially given the history and course the symptoms in question, that followed."

123. Mr Hallmann, in his third set of submissions, submitted the reports provided by the following independent medical experts qualified by the respondent are irrelevant because they are either not qualified or suitably qualified in the fields of ME/CFS and FM; took an incorrect history or failed to take a correct history of his complaints; and failed to carry out an examination of the pelvis, speech and smell:

(a) Ross Baines (physiotherapist)[42];
(b) Professor Oakschott[43];
(c) Dr King[44];
(d) Dr Slezak[45];
(e) Dr Potter; Dr Perides[46];
(f) Greg Schneider (physiotherapist)[47],
(g) and Prof Wakefield[48].

[41] Application – pp 360 – 481 at p 375
[42] report of Ross Baines dated 13 October 2004 – Reply – p 112
[43] report of A/Prof Oakeshott dated 29 November 2004 – Reply p 117
[44] report of Dr King dated 5 November 2004 – Reply – p 124
[45] reports of Dr Slezak dated 21 August 2006 – Reply – p 136 and 24 September 2010 – Reply – p 168
[46] reports of Dr Perides dated 27 May 2011 – Reply – p 355, 20 September 2011 – Reply – p 357 and 29 November 2011 – Reply – p 358;
[47] report of Greg Schneider dated 19 December 2011 – Reply p 378
[48] Reports dated 30November 2002 – Reply – p 386 and 30 September 2013 – Reply – p 449

Respondent's submissions

124. The respondent made oral submissions at the arbitration hearing held on 18 March 2015[49] that Mr Hallmann has not discharged his onus on the balance of probabilities that he suffers with losses of the pelvis, speech and smell as a result of the injury.

125. The respondent submitted that the opinions of Prof Wakefield and other independent medical experts qualified to practise in the New South Wales jurisdiction should be preferred to the opinions of the nominated treating doctors who practise interstate; and who do not understand the principles of assessing permanent impairment under the Table of Disabilities.

126. The respondent submitted that Prof Wakefield in his report dated 24 November 2014[50] reported upon Dr Whiting's comments about pain and tightness in the neck, back, hamstrings, gluteal muscles, lumps in the biceps and triceps, knots in the calves, clusters of lumps in the glands on the back of the neck and near the ear, were present and varied in size when he examined Mr Hallmann, but considered they: "were not clinically significantly enlarged at the time I examined Mr Hallmann and therefore I did not report these features".

127. The respondent submitted that Prof Wakefield acknowledged he is not qualified to conduct a comprehensive neurocognitive assessment of patients, but he did perform a basic neurological assessment of Mr Hallmann[51], which included an assessment of his ability to give a complete comprehensive history, assessment of his cranial nerves and gross neurological functioning, and that Prof Wakefield was aware Mr Hallmann had previously underwent a neurological assessment by a neurologist, which failed to find any evidence of abnormality.

128. The respondent submitted that Prof Wakefield, in addition to assessing Mr Hallmann, had the benefit of watching DVD's of Mr Hallmann's activities.

129. The respondent submitted that Prof Wakefield did not form his opinions based on speculation as suggested by Mr Hallmann and Dr Whiting.

130. The respondent submitted that Dr Potter in his report dated 3 August 2011[52] recorded the following history:

> "In September/October [1996] the pain and aches came in the ankles, knees, groins and later the back."

131. The respondent submitted Dr Bird recorded in his report dated 30 June 2005[53]: "it is noted that in the patient's history, Mr Hallmann went off work with severe back pain that evolved into overall body pain".

132. The respondent submitted that the history taken by Dr Bird was consistent with the history taken by Dr Potter; and is "overwhelming" consistent with the histories of the nominated treating doctors and the independent medical experts of back pain that evolved into overall body pain.

133. The respondent submitted that Dr Bird made no reference to the pelvis in his report of 30 June 2005 nor did he make any assessment of permanent impairment of the pelvis, although he assessed 14 other body parts, using the term "incapacity" instead of "permanent impairment" because of his unfamiliarity with the New South Wales jurisdiction.

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[49] Transcript – 18 March 2015 – pp 29 – 64
[50] Application to Admit Late Documents filed by the respondent on 25 November 2014 – pp 118 – 140 at p 121
[51] supra – at p 134.
[52] Reply – p 179
[53] Application to Admit Late Documents filed by the applicant dated 10 July 2015 – pp 57 – 65 at 62

134. The respondent submitted the reports of Drs Bird, Watson and Whiting refer to a

> "global picture of ME/CFS with persisting FM that affects all body parts, but what the doctors have done is then gone through the impairments that are available under the Table of Disabilities pursuant to section 66 without explaining how those conditions are a consequence of the underlying injury".

135. The respondent submitted there has to be "some sort of intellectual rigour applied" because any complaint Mr Hallmann might have had at the time could be merely put down to the condition without any further investigation to establish the cause of it.

136. The respondent submitted the symptoms complained of must be consistent with the impairment.

137. In respect of loss of smell, the respondent submitted there is no evidence to support a finding that there is permanent impairment.

138. The respondent submitted there has to be some evidence of an impairment resulting from the symptom.

139. The respondent submitted there has been no testing between different types of smell or that his ability to detect scents has been reduced.

140. In respect of speech, the respondent submitted there is some evidence of an inability to find the right word from time to time with the propensity to mumble, and stutter, but there is no evidence that these are a result of the condition of ME/CFS.

141. The respondent submitted that there has to be some evidence of the loss under the Table of Disabilities supported by medical evidence before the matter can be referred to an Approved Medical Specialist for assessment of permanent impairment.

142. The respondent submitted because of the close relationship between Dr Whiting and Mr Hallmann, Dr Whiting has lost his objectivity and impartiality with one or the other misleading the other, or the two of them coming to the wrong conclusion about the pelvis.

143. The respondent submitted the opinion of Dr Whiting that "the pelvis represents one of the first areas of pain identified in the history of Mr Hallmann's ME/CFS"[54] is wrong because pain in the groin and the sacrum are not the pelvis for the purposes of establishing a loss.

144. The respondent submitted the reason for Dr Whiting being wrong about the pelvis as one of the first areas of pain identified in Mr Hallmann's history is the history recorded by Dr Bird of him going off work with severe back pain that evolved into overall body pain, who made no assessment of the pelvis, although he assessed other body parts when he examined him on 21 June 2005 and reported on 30 June 2005.

145. The respondent submitted Mr Hallmann's letter to Dr Lloyd dated 21 November 2006[55] did not refer to the pelvis but stated the following in regard to the "**History of the Illness/Injury**" (emphasis in original):

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[54] report of Dr Whiting dated 26 May 2014 – Application pp 1204 – 1265 at p 1252

[55] Letter dated 21 November 2006 from the applicant to Prof Lloyd – Application to Admit Late Documents filed by the applicant on 18 February 2015 – pp 38 – 67 at p 46

"23. Symptomatically, there was some indications of a problem in August 1995 with severe pain in the biceps following a work out in the gym. The pain eased after some weeks. Having been reasonable [sic] experienced at gym work, I knew this was unusual. Over the weeks through September to November, the pain began in the Achilles to the knee to the groin, the back, the sacrum, then through the back and ultimately into the other muscles of the body (this was over a period of months).

24. On November 29, 1996, the pain hit me firmly in the lower back and groin and that put me off work.

…."

146. The respondent submitted Mr Hallmann saw Dr Sutherland on 17 September 1999, 1 October 1999 and on 14 October 2002, which is closer in time to when Mr Hallmann stopped work, but took no history about the pelvis or complaint of pain in the pelvis, recording in his report dated 9 December 2002[56] the following history:

> "By Mid October, he was troubled by pain in his right Achilles tendon, and then developed a pain in his right groin which seemed to radiate to his lower back and down his right leg.
> …
>
> Mr Hallmann reported on Friday the 29th November 1996 his back symptoms worsened, causing him to go home at midday.
>
> …
>
> I questioned him about what seemed to be dramatic change in the nature of his complaints, with his initial incapacity said to be due to pains in his back and right leg, and then his Achilles tendons, and then a change of claims that he suffered from chronic fatigue syndrome and cognitive difficulties."

147. The respondent submitted that Dr Sutherland recorded the special investigations[57] undertaken of Mr Hallmann at the request of his nominated treating doctors and while an x-ray and a CT scan of the lumbar spine were taken, no scans were taken of the pelvis.

148. The respondent submitted that the complaint of groin pain must relate to the lumbar spine.

149. The respondent submitted that Mr Hallmann was examined by Mr Baines, physiotherapist, at the request on the respondent, on 28 September 2004[58] for the purpose of determining whether ongoing treatment was reasonably necessary as a result of injury, finding physiotherapy treatment is not reasonably necessary "as it is not addressing a defined musculoskeletal condition".

150. The respondent submitted that the complaints made by Mr Hallmann to Mr Baines were "variable and diffuse muscular pain and spasms", described by Mr Hallman as "some central low back pain and cervico thoracic pain", which are eased by rest and massage.

151. The respondent submitted no complaint about the pelvis was recorded by Mr Baines.

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[56] Reply – pp 27 – 28
[57] Reply – p 101
[58] report of Ross Baines dated 13 October 2004 – Reply – pp 112-116

152. The respondent submitted that Mr Hallmann was assessed by Dr Oakeshott, independent medical expert qualified by the respondent, on 29 November 2004[59], who recorded that the current treatment was physiotherapy, twice a week for one and half hours each session involving massage treatment to the tendon-Achilles region of the back of both heels, both calves, hamstring regions at the back of both thighs, the upper back and the neck, and also the outer side of both shoulders, but no complaint or treatment of the pelvis was recorded by Dr Oakeshott.

153. The respondent submitted Dr Oakeshott found no objective evidence of any impairment or loss of function of any part of the body arising from any physical injury or underlying pathology.

154. The respondent submitted the findings of Dr Oakeshott support its submission that Mr Hallmann's interstate nominated treating doctors misunderstood the meaning of "pelvis" in the context of a s 66 claim; and that no intellectual rigour has been applied by his doctors to the question whether there is a causal connection between the pelvic symptoms and the injury or whether the symptoms are limited to the groin, lower back and sacrum.

155. The respondent submitted that Drs Whiting and Bird have formed the view that any complaint in the region of the groin and lower back amount to pelvic pain because pelvic pain is recognised as a symptom of CFS.

156. The respondent submitted that Dr Watson did not refer to the pelvis when he opined:[60]

> "If one examines the symptoms, the condition that is applicable is ME/CFS. You cannot simply carve up these symptoms to avoid a diagnosis of ME/CFS by matching them with other conditions and then claim that is the underlying issue."

157. The respondent submitted Dr Watson "adopts the whole body criteria that both Dr Whiting and Dr Bird adopt"; making the same mistake as Dr Bird that the symptoms of CFS supports Mr Hallmann's complaints that he suffers with a condition of the pelvis.

158. The respondent submitted that Dr Watson made no reference to the pelvis in his report of 7 December 2012.

159. The respondent submitted Dr Watson "fell into the same trap that Drs Whiting and Bird fell into where he says that ME/CFS effects everything".

160. The respondent submitted that Dr Watson, as with Drs Whiting and Bird, failed to apply intellectual rigour when assessing the losses by forming the view that the symptoms of ME/CFS affects everything, including the pelvis as a condition merely because it is one of the symptoms of ME/CFS.

161. The respondent, in support of its submission that Dr Watson included the pelvis because it is a symptom of ME/CFS without assessing whether there was a loss under the Table of Disabilities, referred to Dr Watson's report dated 27 December 2012[61]:

> "<u>Current symptoms:</u>
>
> Symptoms of ME/CFS. Fatigue. Weakness. Sensory abnormalities. Muscles spasms. Chronic widespread major musculoskeletal pain including the pelvic, groin and sacral regions. Multiple neurological symptom including sensory abnormalities as described."

[59] Reply – pp 117 – 123 at p119-120 and p 122
[60] report of Dr Watson dated 7 December 2012 – Application – pp 66 – 112 at p 85
[61] Application – pp 240-359 at p 321

162. The respondent submitted that Drs Bird, Watson and Whiting have not contemplated the meaning of the word “loss”; they have not specified the meaning of the word “pelvis”, and have included the pelvis because it is a symptom of ME/CFS without considering the question of causation.

163. The respondent submitted the same misunderstanding by Drs Bird, Watson and Whiting apply to smell because there is no reference to “loss”.

164. The respondent submitted there is a three-stage process for the assessment of a loss under the Table of Disabilities: firstly, there has to be evidence of a loss of a particular part specified in the table; secondly, there has to be evidence that the loss results from the condition; and thirdly, there has to be an assessment of the percentage of the loss.

165. The respondent submitted that the Commission would not be satisfied that the complaints recorded by the doctors, referring to nominated treating doctors and independent medical examiners, is sufficient to find there is evidence of a loss under the Table of Disabilities.

166. The respondent again submitted that no weight should be given to the opinions of Drs Bird, Watson and Whiting because they have lost their objectivity and impartiality; effectively became advocates for Mr Hallmann in his case and breached their obligations under Practice Direction 3.

167. The respondent submitted that Drs Bird, Watson and Whiting, unlike Prof Wakefield, made no concession on any single issue in terms of any secondary condition or treatment modality, and the lack of concession demonstrates their lack of objectivity and lack of compliance with Practice Direction 3.

168. The respondent submitted that Drs Bird, Watson and Whiting have not considered whether any complaint or condition of the pelvis relates to alternative possibilities such as the onset of arthritis in the hips for a worker approaching 40 years of age.

169. The respondent submitted that Drs Bird, Watson and Whiting did not refer Mr Hallmann for investigations such as an x-ray of the pelvis or hips to exclude any other plausible and common explanation as to why pelvic symptoms may emerge 15 to 17 years after the onset of ME/CFS.

170. The respondent submitted that Drs Bird, Watson and Whiting have assumed without any proper analysis that Mr Hallmann’s complaints of bodily symptoms must have resulted from ME/CFS with persisting FM.

171. The respondent submitted there was no proper foundation upon which Drs Bird, Watson and Whiting based their opinion to conclude that Mr Hallmann suffers with conditions of the pelvis, speech and smell as a result of ME/CFS with persisting FM.

172. The respondent submitted Mr Hallmann demonstrated by his oral submissions at the arbitration hearings that he is intelligent and articulate, and the Commission should take quasi-judicial notice of his speech.

Applicant’s submissions in reply

Oral submissions

173. Mr Hallman made oral submissions in reply at the arbitration hearing on 18 March 2015[62].

[62] Transcript – 18 March 2015 – pp 65 – 72

174. Mr Hallmann submitted that in accordance with Table 4.3 the WorkCover Guidelines[63], the pelvis is made up of the hipbone (acetabulum), the sacrum and the coccyx.

175. Mr Hallmann submitted that assessment of the pelvis (assessment of whole person permanent impairment of the spine involving pelvic fractures) includes:

    (a) non-displaced healed fractures;
    (b) traumatic separation of the pubis symphysis;
    (c) sacroiliac joint dislocations or fracture dislocations, and
    (d) fractures of the coccyx and acetabulum (hipbone).

176. Mr Hallmann submitted that the pain went from the groin to the back, not that he was suffering with independent back pain.

177. Mr Hallmann submitted this musculoskeletal condition affected by ME/CFS has not been denied by the respondent; it is not a defined musculoskeletal injury.

178. Mr Hallmann submitted that he is not responsible for what Mr Baines and Dr Oakeshott recorded but he complained about groin pain going to the back, and the sacrum when examined by them.

Written submissions – dated 10 July 2015 and 17 July 2015

Pelvis

179. Mr Hallmann, in support of his submission as to the make-up of the pelvis, referred to Chapter 15.14 of AMA5 at p 427, which states:

> "The pelvis is composed bilaterally of three bones: the ilium, the ischium and the pubis, forming a ringlike structure. Each ilium is attached to the sacrum via the sacroiliac synchondrosis. The pelvis including the symphysis pubis, assists in the transfer of body weight to the lower extremities."

180. Mr Hallmann submitted that Table 15-19 at p 428 of AMA5 and the *WorkCover Guides for the Evaluation of Permanent Impairment 3rd edition* (4th edition since 1 April 2016) is used for assessing whole person impairment of pelvic disorders.

181. Mr Hallmann submitted that the "groin pain is associated with the joints, muscles and tendons", which joins the pelvis.

182. Mr Hallmann submitted the respondent's submission that he does not suffer with a condition of the pelvis is incorrect because their submissions were premised on the assertion that the groin, sacrum, coccyx, hips and sacroiliac joint, and associated muscles and tendons, are not part of the pelvis.

183. Mr Hallmann submitted that a historical review of the documentary evidence establishes the onset of the ME/CFS with persisting FM occurred in October 1996, and that the symptoms began in the right Achilles, progressed to the right knee into the right groin, then the right hip and the sacroiliac joint, and then progressed throughout the body.

184. Mr Hallmann submitted the respondent's submission that there is no evidence of him complaining of symptoms about the pelvis to medical providers, including independent medical examiners, should be rejected.

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[63] WorkCover Guides for the Evaluation of Permanent Impairment – 3rd edition – 1 February 2009 at p 33

185. Mr Hallmann submitted that the respondent's submission that "it wasn't mentioned in Dr Bird's report of 2005, which is nine years after the MECFS conditions has arisen"[64], should be rejected on a fair reading of Dr Bird's report.

186. Mr Hallmann, in support of his submission that he suffers with a condition of his pelvis as a result of the ME/CFS with persisting FM, referred to the following medical reports and records:

(a) Mr Neil Mansen – patient record[65] – first seen on 4 November 1996:

"fatigue", "low back pain", "joint pain/stiffness" "walking problems" " currently has a bit of pain in the right groin & hip, some back pain and Achilles Problems."

(b) Neil Mansen – report dated 26 February 199966:

"treatment to his groin hip, low back and Achilles"; suffering with "Lumbar Facet Syndrome and an overlying Scaroiliac (sic) Syndrome."

(c) Dr Boey – report dated 19 March 199767 recording the following:

"He first saw Neil Mansen at the beginning of November 1996 because of right groin pain and ankle pain of two weeks duration. He was told his right hip was out and his spine was not straight. He first noted pain while driving. He was treated by Neil without improvement. When first seen he was treated as lumbo-sacral strain. As he had not responded to treatment after four weeks it was decided to investigate him with x-ray and CT scan."

(d) Dr Ghabrial – report dated 20 December 1999[68] - "chronic widespread areas of pain."

(e) Dr Sage – report referred to in report of Dr Sutherland dated 9 December 2002[69]:

"multiple areas of discomfort which appear to be mainly related to the trunk, interscapular areas, thorocolumbar area, lumbar-sacral area, right iliac fossa or groin, also right leg going down to the knee" … "woke up with a severe, painful lower back, … following the cute episode of 20.11.96, he virtually had to spend the month flat in bed."

(f) Dr Pacey – report dated 21 May 1997[70]:

"… he had been experiencing problems with hip, groin and knee pain on the right hand side and some tendo Achilles problem for about 6-8 weeks prior to the onset of his low back pain … About 29 November 1996 he woke with quite significant right sided low back pain and continuing right groin pain. His current symptoms are described as right groin pain which is the worst pain. This radiates to the anterior right thigh … Stress tests for sacroiliac joint function was negative apart from palpation of the joint

[64] transcript – 18 March 2015 – pp 62-63
[65] patient record – Application – pp 1724-1725
[66] Application to Admit Late Documents filed by the applicant – 10 July 2015 – p 27
[67] supra – p 18
[68] Reply – p 44
[69] supra at p 30 and p 77
[70] Application to Admit Late Documents filed by the applicant – 10 July 2015 – pp 20-21

which was tender on the right hand side and reproduced right groin pain. He is noted to have tight iliotibial band both on the right and left side and tenderness over the insertion of the iliotibial band. There is tenderness over the medial collateral ligament on the right particularly at its distal insertion. There is tenderness over the greater trochanter on the right side and at the insertion of the gluteus medius and external rotators of the hip…".

(g) Dr Pacey – report dated 3 December 1997[71]:

"Dr. Clair Hollo … is considering diagnostic studies of the lumbar discs and the sacroiliac joint … He is having massage and myofascial releases …".

(h) Dr Pacey – report dated 11 January 2001[72]:
"right sided lower back pain, extending into the right groin and leg, with some aching of his Achilles tendon."

(i) Mr Chris Downs, physiotherapist – report dated 11 August 1997[73]:

"… I first saw him on 23 July 1997, regarding low back pain which had its onset in mid-October 1996 and for which you have seen previously. He did not complain of any neurological symptoms and has not been working since 1996… On examination, lumbar spine movements were all restricted by pain with straight leg raising on the left at 46 [degrees] and on the right at 50 [degrees]. The left sacro-iliac joint was restricted on testing and the left facets of the lower thoracic and upper lumbar spine were tender on palpation. The upper lumbar spine and thoracic spines were hypomobile and there was some muscle spasm on the left paravertebrals and the left gluteal. There was nothing remarkable on examination apart from the fact that posture was poor and there was atrophy of the abdominal and gluteal musculature."

(j) Dr Stewart – report dated 9 July 1998[74]:
"Muscle pain or multi-joint pain without redness/swelling."

(k) Dr Stewart – report dated 5 December 2000[75]:

"Dr Pacey has prescribed a graded exercise program for his CFS and low back pain."

(l) Bioscreen Checklists[76] – questionnaire completed by applicant – 5 July 1999:

"Frequent Muscle Cramps
Joints that hurt with movement
Sore throats or nasal infections
Muscle soreness or stiffness
Allergies
Difficulty using words or language."

[71] supra – p 26
[72] Reply – p 44
[73] Reply – pp 20 – 21
[74] supra – p 4
[75] supra – p 45
[76] supra – pp 6 – 9

(m) Mr Darren Glendenning – physiotherapist – report dated 14 December 2000[77]:

"October 1996 – Geoff started to feel pains in both Achilles and knees. He saw Chiropractor (Dr. Neil Mansen in Adamstown). Treated twice a week. Pain moved to the groin. On 29 November 1996, severe pain was felt in the lumbar spine and kidney region. Geoff was also having problems most noticeable with sleeping fatigue and headaches…

Current history – Geoff presents complaining of a general body ache that is aggravated by activity. He also has tightness/ache in his right lumbar spine and left knee …

Lumbar Spine
Posture – Anteriorly titled pelvis with poor abdominal muscle tone …
Active movements – Flexion – pain in low lumbar spine at the end range – Extension – pain centrally in mid lumbar spine at end of range
– Left Lateral Flexion – pain right low lumbar spine at end of range
– Right Lateral Flexion – full pain free range of movement
– Left rotation – mild lumbar pain at end range
– Right rotation – mild lumbar spine pain at end of range
Lying prone – pain in lumbar spine after one minute
Lying supine – pain in lumbar spine after one minute
Abdominals – fatigue + after eight crunches
Palpation – Tender low lumbar spine bilaterally
– Tender around PSIS, ASIS and lower abdominals bilaterally."

(n) Dr Hession – report dated 13 April 2001[78] – MRI scan of the lumbo-sacral spine – 9/7/97 – reported showing mild disc desiccation at the L5/S1 level.

(o) Dr Lee, psychiatrist – report dated 2 September 2002[79]:
"He said that by September 1996, he was beginning to get pains in his legs, which progress to his knee, groin and, by November 1996, to his back which is when he stopped work because of the pain".

(p) Dr Donohoe – report dated 12 March 2004[80]:
"… developed right-sided "Achilles pain' in his legs. This soon spread to his right knee, then his right groin … pain in the back, groin, and Achilles area, and this progressed through his body …"

(q) Dr Bird – report dated 10 May 2005[81]:

"He was tender to tender to palpation, 5-6/10, at midline in the lumbar area and in the sacro-iliac joint and the area where the sciatic nerve exists. He was in discomfort when he was lying on the couch. It is noted in the patient's history, Mr Hallmann went off work with severe back pain that evolved into overall body pain. Throughout the past 9 years back pain has been a repeated issue since the onset of the illness. … nasally Based Staphylococcus… 5. *Speech Incapacity* – regarding Mr. Hallmann's

[77] supra – pp 29 – 23
[78] Application to Admit Late Documents filed by the applicant – 15 September 2014 – p 3
[79] Reply – p 14
[80] Application to Admit Late Documents filed by the applicant – 14 October 2014 – pp 31-32
[81] Application to Admit Late Documents filed by the applicant – 10 July 2015 – p 60 and p 63

permanent loss of efficient use of speech, Mr. Hallmann reports having problems with slurring, mumbling and jumbling of words, being worse when he is tired. I have personally witnessed all of the above symptoms over the past two years. I would estimate the permanent loss of efficient use of speech at 9%."

…"

(r) Dr Zlezak report dated 21 August 2006[82]:

"Mr Hallmann stated that he developed the onset of right lumbosacral pain and by September 1996 had also developed pain in the right groin, right calf and over the right Achilles tendon. With the passage of time his right lumbosacral pain increased in intensity and despite chiropractic treatment, symptoms failed to improve and he was forced to stop work."

(s) Elva Fitzell – physiotherapist – report dated 10 March 2008[83]:

"My management program is to increase function, range of motion of joints + muscles – to address exacerbations of pain + dysfunction aggravated by work, exercise." – report dated 21 December 2007:

"The client has had flu for the last two weeks resulting in:

Increased Fibromyalgia
Increased joint pain
Increased pain of the kidney area and sacrum
Increased piriformis pain
A complete lack of energy."

187. Mr Hallmann submitted that a historical review of the documentary evidence provides a very clear history that the onset of ME/CFS with persisting FM occurred in October 1996, and that the symptoms began in the right Achilles, progressed the right knee into the right groin then right hip and sacroiliac joint, and then throughout the body.

188. Mr Hallmann submitted the respondent's submission that there is no history of pelvis problems recorded in the medical reports should be rejected.

189. Mr Hallmann submitted that the condition of the pelvis results from the accepted injury (ME/CFS with persisting FM) for the following reasons:

(a) The diagnosis of ME/CFS with persisting FM meets the diagnostic criteria of the 2003 Consensus Criteria.

(b) The criteria for CFS included "muscle pain" and "pain in the joints without swelling or redness"[84].

(c) The criteria also references' fatigue, post exertional malaise, muscle weakness and lymph modes[85].

(d) The 2003 Consensus Criterial includes;

[82] Reply – p 138
[83] Application to Admit Late Documents filed by the applicant – 10 July 2015 – p 38
[84] report of Dr Whiting dated 24 March 2013 – Application – p 40
[85] report of Dr Whiting 11 July 2014 – Application – pp 408-409

> "Pain: There is a significant degree of myalgia. Pain can be experienced in the muscles and/or joints, and is often widespread and migratory in nature."[86]

(e) The criteria for Fibromyalgia included:

> "Pain above and below the waist … Low back pain is considered lower segment pain". There are two sites trigger points being gluteal and trochanter points."

190. Mr Hallmann submitted the pelvic symptoms (muscle and joint pain in the low back with trigger points of the gluteal and trochanter) are "an inherent part of the diagnosis of ME/CFS and Fibromyalgia" resulting from the injury.

191. Mr Hallmann, in support of his submission that the symptoms of the groin and sacrum pain is part of the pelvis and a condition of ME/CFS with persisting FM, referred to the report of Dr Bird dated 8 March 2010[87]:

> "4. ***Permanent Impairment of Pelvis*** [emphasis in original] – Mr Hallmann's symptoms original symptom pattern centred on the pelvis in the Sacrum and groin.
>
> …
>
> It is noted that in the patient's history, Mr. Hallmann went off work with severe back pain on 29/11/1996 that evolved into overall body pain including the pelvis in 1996/1997. Throughout the past 13 years Pelvis pain has been an ongoing issue since the onset of the illness."

192. Mr Hallmann, in support of his submission that the symptoms in the groin, hips, sacrum, sacroiliac and coccyx are part of the pelvis and a condition of ME/CFS with persisting FM, referred to the 2003 Consensus criteria:

> "Pain: There is significant degree of myalgia. Pain can be experienced in the muscles and/or joints, and is often widespread and migratory in nature."

193. Mr Hallman submitted that the criteria for FM as set out in the 2003 Consensus criteria includes:

> "Pain above and below the waist … Low back pain is considered lower segment pain".

194. Mr Hallmann submitted the investigations and medical treatment since the onset of his symptoms establishes the pelvic symptoms are a condition of ME/CFS with persisting FM:

> "• x-ray, CT and MRI scans – 1996 and 1997
> • referral to Dr Pacey (rehabilitation specialist) in 1997
> • referral to Professor Ghabrial, orthopaedic surgeon in 1997
> • chiropractic and physiotherapy since 1996
> • referral to Dr Watson (musculoskeletal and rehabilitative medicine) in 2006
> • use of Lyrica from 2007 until 2011 for pain management
> • pathology testing (creatine kinase, FSH, Ferritin) for past 15 years
> • CPET investigation in 2012 – post-exertional malaise
> • MRNA Gene Expression confirming post-exertional fatigue and pain."

[86] 2003 Consensus Criteria – Application to Admit Late Documents filed by the applicant dated 16 September 2013 – p 54
[87] Application – p 35

195. Mr Hallmann submitted the evidence establishes on the balance of probabilities that he suffers with a condition of the pelvis, which is a symptom of ME/CFS with persisting FM, as a result of the injury.

196. Mr Hallmann submitted that the medical history discloses the symptoms of the pelvis as a result of the ME/CFS with persisting FM have been present across 19 years and include:

> "• right groin pain
> • right hip pain
> • chronic widespread pain
> • pain radiating to anterior right thigh
> • pain in the right buttock
> • right iliotibial band on right and left
> • tenderness of right greater trochanter
> • tenderness at insertion of the gluteus maximus and external rotators of hip
> • tight hamstrings
> • restricted left sacroiliac joint
> • muscle spasms on left paravertebrals and left gluteal
> • severe pain in lumbar spine and kidney region
> • anteriorly tilted pelvis with poor abdominal tone
> • pain right low lumbar spine at end of range
> • tenderness in sacroiliac joint
> • right lumbrosacral pain of increased intensity
> • increased pain of the kidney area and sacrum
> • increased piriformis pain
> • progression of pain throughout."

197. Mr Hallmann submitted that the history provided to medical providers of muscle pain in the pelvis and pelvic region (groin, low back, kidneys, buttocks, piriformis, thigh, iliotibial band); muscle spasms on left paravertebrals and left gluteal, and joint pain across the sacrum, hips, sacroiliac joint, and greater trochanter are symptoms which constitute Fibromyalgia pain, and described under the 2003 Consensus Criteria as an "overlap syndrome".

198. Mr Hallmann submitted that FM, first diagnosed by Dr Willoughby in April 1998 and confirmed by Dr Stewart in May 1998, is a co-morbid condition of ME/CFS.

199. Mr Hallmann submitted the opinions of Drs Bird, Watson and Whiting should be preferred to the opinions of the respondent's independent medical experts, Drs Slezak and Potter and Prof Wakefield, for the following reasons:

> "Dr. Slezak – There is no injury or impairment;
>
> Dr. S. Potter – There is no diagnoses of ME/CFS or FM, hence no impairment;
> Professor Wakefield – There are diagnoses of CFS and FM and that the applicant fulfils the criteria for ME/CFS, but he is silent on the issue of pelvis impairment."

200. Mr Hallmann submitted there is no medical evidence to support the respondent's submissions that he does not suffer with symptoms of the pelvis, which are a condition of ME/CFS with persisting FM resulting from the injury.

Loss of sense of smell

201. Mr Hallmann submitted the loss of smell is a condition of the injury (ME/CFS with persisting FM).

202. Mr Hallmann submitted that the symptoms associated with loss of smell are:

> "(a) An inherent part of the symptoms of the compensable injury being ME/CFS; and/or
>
> (b) An inherent part of the symptoms of the overlap syndrome, also the compensable injury being FM."

203. Mr Hallmann referred to the 2003 Consensus Criteria at point 2.1 in support of his submission that "altered smell"; "sinusitis" and "sensitivities to chemicals", were identified as a symptom of ME/CFS, confirmed by the 2011 International Criteria, and the 2014 Primer.

204. Mr Hallmann, in support of his submission that he suffers with loss of smell as a result of ME/CFS, referred to the following medical histories:

(a) Pathology tests – Hampson Pathology – 8 March 1996[88]:

> "ongoing cough and sinusitis since arriving in Newcastle."

(b) Medication – Rhinocort was prescribed for sinus symptoms[89].

(c) Mr Mansen (chiropractor) – new client form dated 4 November 1996[90]:

> "nasal blockage"

(d) CT scan – 16 June 1998 – paranasal sinuses[91].

(e) Staph infections – Bioscreen – 24 August 1998[92]:

> "Staphylococcus positive (sinus based)."

(f) Dr Stewart – reports dated 13 May 1998[93], 9 July 1998[94] and 29 July 1999[95]:

> "Left nasal swab – gram stain & culture. Right nasal swab – gram stain & culture."
>
> "Lowered tolerance of alcohol, drugs or odours from volatile chemicals (incl. chemical sensitivities."
>
> "He has sinusitis + evidence on ongoing infection."

(g) CT scan – 31 August 1999 – of the Mastoids[96] - report of Dr Stewart dated 31 August 1999[97]:

> "This appears to correspond to a small soft tissue nodule probably a lymph node … The underlying mastoid air cells are well developed and clear of disease."

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[88] Application to Admit Late Documents filed by the applicant dated 10 July 2015 – pp 40 – 41
[89] supra – p 42
[90] Application – pp 72-73
[91] Reply – p 101
[92] Reply – p 102
[93] supra - 101
[94] Application to Admit Late Documents filed by the applicant dated 10 July 2015 – p 4
[95] supra – p 43
[96] Application to Admit Late Documents filed by the applicant dated 10 July 2015 – p 43
[97] Reply – p 102

(h) Bioscreen Checklists – questionnaire completed by the applicant – 5 July 1999[98]:

> "… Sore throats or nasal infections
> … Muscle soreness or stiffness
> … Allergies"
>
> Presentation of symptoms on 20 December 2000:
> "… Sore throats or nasal infections
> … Muscle soreness or stiffness
> … Allergies"

(i) Darren Glendenning (physiotherapist) – report dated 14 December 2000[99]:

> "April/May 1998 – … He was referred to Bioscreen for staph test which was positive.
>
> March – July 1999 – Exposed to noise, dust and fumes at University House and Geoff's condition has deteriorated.
>
> July – November 1999 – continuation of dust and fumes exposure at University House."

(j) Dr Reeves (immunologist) – report dated 2 August 2001[100]:

> "Geoffrey has also been found to have a 'Staphylococcus toxin' which he believes is in his sinuses … Geoffrey gives a history suggestive of irritable bowel syndrome and the presence of sneezing and rhinorrhoea raises the question of incompletely controlled atopic illness … I would recommend a trial of intranasal steroid rhinocort to attempt to address any contribution on incompletely controlled nasal allergy to Geoffrey's symptoms."

(k) Dr Hession – reported dated 13 April 2001[101]:

> "I am aware of the results of x-rays of his chest and paranasal sinuses, which were done on 05.03.96. In both instances, no abnormality was detected."

(l) Dr Schofield (neuropsychiatrist) – report dated 16 July 2002[102]:

> "In 1995, he was diagnosed with asthma and developed sinus problems".

(m) Dr Lee (psychiatrist) – report dated 2 September 2002[103]:

> "He consulted Dr Patel, who sent him for X-rays of his chest and sinuses and prescribed him a bronchodilator and inhaler.

[98] Application to Admit Late Documents filed by the applicant dated 10 July 2015 – pp 6-7
[99] supra – pp 29-33
[100] Application to Admit Late Documents filed by the applicant dated 9 October 2015 – pp 2-4
[101] Application to Admit Late Documents filed by the applicant dated 15 September 2014 – p 3
[102] Application to Admit Late Documents filed by the applicant dated 26 September 2014 – p 22
[103] Reply – p 12 and p 15

…

He told me he uses a nasal spray and a combination of baking soda and sea salt to rehydrate himself and that he has a mould allergy."

(n) Dr Coleman – report dated 9 October 2002[104]:

"Mycoplasma and also had an intercurrent staph infection … When I saw him he also had symptoms of nasal blockage, sneezing and anterior rhinorrhea and had a tendency to snore, but there is no evidence of apnoea. He had recurrent ocular irritations with symptoms of photophobia. Initially he developed a sensitivity to different chemical including perfumes and petrol which triggered headaches."

(o) Dr Sutherland – report dated 9 December 2002[105]:

"Mr Hallmann was also said to have chronic bacterial sinusitis, due to an infection with a pathogenic staphylococcus. This prompted the further prescription of antibiotics.

…

Paranasal Sinuses – Hunter Medical Imaging"

(p) Dr Donohoe – reports dated 12 March 2004 and 10 October 2014[106]:

"Occasional steroid nasal spray … delta-taxin positive, coagulase negative staphylococcus isolated on nasal swab, suggesting superficial infection. This is again associated with persisting fatigue and musculoskeletal pain in chronic fatigue syndrome, and compatible with the symptoms Mr Hallmann describes.

…

"Stuffed nose"

(q) Dr Harvey – report dated 21 August 2006[107]:

"During June 1995, he was sick with cough and post nasal drip. He sought advice from Dr Patel then and had x-rays. By March 1996 he again suffered upper respiratory track symptoms."

[104] supra at 102 – p 20
[105] Reply – p 28 and p 101
[106] Application to Admit Late Documents filed by the application dated 9 October 2014 – pp 13-17
[107] Reply – p 138

(r) Dr Bird – reports dated 10 June 2005[108]: and 8 January 2006[109]

> "Nasally Based Staphylococcus Infection"
>
> …
>
> "Medications – I have recommended that Mr Hallmann utilise three anti-biotic creams for the sinus symptoms that have persisted since 1995. There has been a persisting diagnosis of staph infection since 1997. This is a symptom and infection that often accompanies CFS.I have prescribed:
>
> (a) Fucidus Ointment;
> (b) Bactroban Ointement;
> (c) Nemdyn."

(s) Symptom severity list completed by the applicant:

(a) 29 November 2008[110]

"Sensitive to light, noise or odours	moderate
New Sensitivities to food/medication/chemicals	moderate
Other symptoms: Headaches"	

(b) 27 May 2009[111]

"Sensitive to light, noise or odours	severe
New Sensitivities to food/medication/chemicals	severe
Other Symptoms: Irritable, Pain in Joints"	

(c) 31 August 2009[112]:

"Sensitive to light, noise or odours	severe
New Sensitivities to food/medication/chemicals	moderate
Other symptoms: irritable, unable to think, Severe Flu"	

(t) Dr Bird – report dated 4 March 2010[113]:

> "*Nasally Based Staphylococcus Infection* – Bioscreen Pty Ltd, University of Newcastle, 1998. Mr. Hallmann's report reveals he had an infection with Delta Toxin in 1998 and was subject to 2 years of antibiotics for this issue. He continues to report sinus symptoms consistent with that experienced in 1998.
>
> …

[108] Application to Admit Late Documents filed by the applicant dated 10 July 2015 – p 60
[109] Application – pp 1735-1736
[110] supra at 108 – p 11
[111] supra – p 13
[112] supra – p 15
[113] supra – p 21 and pp 48-49

> "Loss of efficient Use of Smell – Regarding Mr. Hallmann's permanent impairment of smell, he reports extreme sensitivity to items such as petrochemicals (e.g. petrol and diesel), perfumes, deodorants and the like. When this occurs, it leads to a headache or migraine. See: (Ockerman, P.A., "Antioxidant Treatment of Chronic Fatigue Syndrome: Clinical Practice of Alternative Medicine, 1(2): 88-91, 2000 at p. 89; Carruthers et al see "Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Clinical Working Definition, Diagnostic and Treatment Protocols: *Journal of Chronic Fatigue Syndrome* Vol 11 (1) 2003 at p 101, 104) 35.
>
> Taking all of the above into consideration and the documented findings of the past, I would estimate Mr. Hallmann's permanent impairment of smell (i.e. loss of efficient use) to be 15%.
>
> Due to the nature of the illness, virtually every aspect of the patient's body is affected. The above is an incapacity assessment within the bounds of the Table of Maims as supplied by the patient."

205. Mr Hallmann submitted the evidence establishes the onset of the sinus symptoms are an inherent condition of ME/CFS:

> "
> - allergy testing in 1994 and 2001
> - identification of Delta Toxin in 1998
> - treatment with Rhinocort
> - identification of allergies to rag weed (Dr Reeves) via pathology and allergy testing by Dr Coleman
> - x-ray and CT scans of sinuses and mastoids 1996 and 1999
> - treatment with Bactroban from 1998
> - referral to Dr Coleman (allergist) in 2001
> - referral to Dr Reeves (immunologist) in 2001
> - monitoring of sinus issues with scans"

206. Mr Hallmann submitted the sinus symptoms, nasal drip, staph infection and sensitivity to chemicals are symptoms or conditions of MC/CFS resulting in loss of sense of smell.

207. Mr Hallmann submitted the opinions of Drs Bird, Whiting and Watson should be preferred to the opinions of Drs Slezak and Potter, and Prof Wakefield for the following reasons:

> "Dr. Slezak – There is no injury or impairment;
>
> Dr. S. Potter – There is no diagnosis of ME/CFS or FM, hence no impairment, and
>
> Professor Wakefield – There are no references to ENT symptoms. He is silent as to the issue of the smell."

208. Mr Hallmann submitted the opinions of Drs Bird, Whiting and Watson establishes on the balance of probabilities that he suffers with loss of smell, which is a condition of MC/CFS, as a result of the injury.

Loss of power of speech

209. Mr Hallmann submitted he suffers with loss of speech resulting from cognitive and memory problems, which are primary and secondary problems of ME/CFS, and that the evidence of Drs Bird, Watson and Whiting establishes on the balance of probabilities a causal link or chain between the loss of power of speech and the injury.

210. Mr Hallmann submitted that the symptoms associated with loss of speech are:

> "(a) An inherent part of the symptoms of the compensable injury being ME/CFS; and/or
>
> (b) An inherent part of the symptoms of the overlap syndrome, also the compensable injury being FM."

211. Mr Hallmann referred to the 2003 Consensus Criteria and the 2011 International Criteria in support of his submission that loss of speech is a condition of ME/CFS.

212. Mr Hallmann submitted that the injury of ME/CFS with an overlap of FM generates its own pathology, which impacts upon speech, such as issues of cardiac, respiratory, haemotopoietic, endocrine, dysphasia and neurocognitive deficits.

213. Mr Hallmann, in support of his submission that he suffers with the loss of power of speech as a result of ME/CFS, referred to the following medical histories:

(a) Bioscreen Checklists – questionnaire completed by the applicant – symptoms[114]:

(a) 5 July 1999

"… Mind Going Blank	4
… Forgetfulness	4
… Difficulty Using Words or Language	4"

(b) 20 December 2000[115]:

"… Mind Going Blank	2
… Forgetfulness	2
… Difficulty Using Words of Language	2
… Mental Confusion or loss of Train of Thought	2"

(b) Dr King – report dated 10 August 2000[116]:

"From the diagnosis of Chronic Fatigue Syndrome, or from a coherent interpretation of Mr Hallmann's tests, measures, and professional reports, there is no room for doubt that Mr Hallmann is:

a. a man of underlying superior intelligence;

b. currently suffering from a debilitating condition which attenuates his physical durability and specifically depletes certain aspects of his ability to concentrate, focus and apply his considerable intelligence …

[114] Application to Admit Documents filed by the applicant dated 10 July 2015 – pp 6-7
[115] supra – pp 8-9
[116] Application to Admit Late Documents filed by the applicant dated 26 September 2014 – pp 1-2

> Mr Hallmann's psychological tests indicate that in certain CFS-specific domains he is functioning well below his underlying mental ability. Were his worst scores interpreted as a measure of his IQ, he would not be at University Standard at all, with a score in the mid 80's, whereas his best scores place his IQ well above 130. This difference of more than 40 IQ points is exactly what I have professionally noted in similar cases of CFS, and is only matched by cases of actual physical, traumatic brain damage."

(c) Darren Glendenning (physiotherapist) – report dated 14 December 2000[117]:

> "June 1998 … Geoff states that his symptoms at this time included depression, severe body pain, major muscle spasms … severe fatigue, brain fog problems (cognitive dysfunction), gut dysfunction and migraines (induced by severe light phobia)."

(d) Dr Donohoe – report dated 10 October 2004[118]:

> "chronic fatigue loss of efficient use of speech … 10%"

(e) Dr Bird – reported dated 30 June 2005[119]:

> "*Cognitive disturbances* – identified and measured in 1999 (Dr. Reid, Psychologist), 2000 (Dr. Michael King, Psychologist) and 2002 (Dr. John Anderson, Psychologist) …
>
> *Speech incapacity* – Regarding Mr. Hallmann's permanent loss of efficient use of efficient use of speech. Mr. Hallmann reports having problems with slurring, mumbling and jumbling of words, being worse when he is tired. I have personally witnessed all of the above symptoms over the past two years. I would estimate the permanent loss of efficient use of speech at 9%."

(f) Symptom severity list completed by the applicant:

(a) 29 November 2008[120]

> "Memory Disturbance: Poor short-term memory Moderate
> Confusion and difficulty concentrating Moderate
> Difficulty retrieving words or saying the wrong word Moderate
> Other Symptoms: Sinus, headaches, coughing"

(b) 28 February 2009[121]

> "Memory Disturbance: Poor short-term memory Moderate
> Confusion and difficulty concentrating Severe
> Difficulty retrieving words or saying the wrong word Severe
> Other symptoms: Headaches"

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[117] supra – pp 1-2
[118] Application to Admit Documents filed by the applicant dated 13 October 2014 – p 47
[119] Application to Admit Late Documents by the applicant dated 10 July 2015 – pp 61-63
[120] Application to Admit Late Documents filed by the applicant dated 10 July 2015 – p 9
[121] supra – p 11

(c) 27 May 2009[122]

"Memory Disturbance: Poor short-term memory Moderate
Confusion and difficulty concentrating Moderate
Difficulty retrieving words or saying the wrong word Moderate
Other Symptoms: irritable, Pain in Joints"

(g) Dr Bird – report dated 17 July 2009[123]:

"The symptoms and diagnosis can be considered a permanent condition. Each condition causes its own impact and should be treated separately (MC/CFS primarily has issues of fatigue, endurance, concentration, memory; Fibromyalgia relates to muscle and joint pain; Scotopia/Irlen Syndrome relates processing speed, headaches, reading speed, eye pain and comprehension; NMH to blood pressure issues related to pressure – particularly standing and sitting with legs down …)

At present, he struggles with the following symptoms:
- Short-term memory problems;
- Cognitive dysfunctions (including difficulties with concentration, upper thinking, comprehension, etc)
- Fatigue (including post-exertional and resting)
- Pain (including neck pain, body pain, upper back and shoulders – exacerbated by sitting
- Irritable bowel
- Headaches and migraines
- Eye sensitivity (including sensitivity under fluorescent light, slower reading and comprehension, headaches, dry eyes, itchy eyes)
- Blood pressure issues (with the incline of legs the best method for countering whilst sitting …

In the past, he has either failed to finish the exam or struggled to finish the exam. In short it becomes a test of endurance between his deteriorating symptoms and the passing of time."

(h) Dr King – report dated 14 September 2009[124] :

"Mr Hallmann presented to the clinic and reported being neither dramatically 'bad' nor 'good'. It is my experience that it is common for CFS clients to have days which they report as 'bad', although it is my experience that the targeted scores vary little from 'good' to 'bad' days.

He showed some signs of tiredness during the testing session, and was a little agitated with his problems of finding the right word ('word finding difficulty') in some of the verbal assessments."

[122] supra – p 13
[123] Application to Admit Late Documents filed by the applicant dated 1 October 2014 – pp 22-23
[124] Application to Admit Late Documents filed by the applicant dated 26 September 2014 – p 9

214. Mr Hallmann submitted the evidence establishes the onset of the speech symptoms is associated with the onset of the condition of ME/CFS, being neurocognitive in origin:

> "
> - MRI brain scans in 1999 and 2009
> - SPECT Brain scans in 2003 and 2012
> - EEG and QEEG scans in 2001, 2002 and 2013
> - psychological testing in 1999, 2000 and 2009
> - monitoring and observation"

215. Mr Hallmann submitted Dr Bird's opinion that slurred speech, mumbling and jumbling of words, stuttering and stumbling in speech are symptoms common in ME/CFS[125], and should be accepted.

216. Mr Hallmann submitted cognitive function is a symptom of ME/CFS associated with mumbling verbalisation and difficulty in word finding[126].

217. Mr Hallman submitted that Dr Watson's opinion as to loss of power of speech as a result of ME/CFS should be accepted for reasons set out in Dr Bird's reports of 4 March 2010 and 27 December 2012[127].

218. Mr Hallmann submitted judicial notice should be taken of his difficulties with speech when speaking during arbitration hearings.

219. Mr Hallmann submitted that the opinions of Drs Bird, Watson and Whiting should be preferred to the opinions of the respondent's independent medical examiners, Drs Slezak and Potter, and Prof Wakefield for the following reasons:

> "Dr. Slezak – There is no injury or impairment;
>
> Dr. S. Potter – There is no diagnosis of ME/CFS or FM, hence no impairment;
>
> Professor Wakefield – There is no reference to ENT symptoms."

220. Mr Hallmann submitted there is no medical evidence to support the respondent's submissions that he does not suffer with the loss of power of speech, which is a condition of ME/CFS, resulting from his injury.

Respondent's written submissions – 14 August 2015

221. The respondent submitted that a loss may result from injury by way of a direct connection to the injurious event or as a natural consequence of that event.

222. The respondent submitted that the injurious event or incident is the mechanism by which an injury within the meaning of s 4 of the 1987 Act is sustained[128].

223. The respondent submitted the relevant injury within the meaning of s 4 of the 1987 Act is the pathology that has arisen out of or in the course of employment, and that a "personal injury" as explained by Gleeson CJ and Kirby J in *Kennedy Cleaning Services Pty Ltd v Petkoska*[129] is "a sudden and ascertainable or dramatic physiological change or disturbance of the normal physiological state".

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[125] report of Dr Bird dated 8 March 2010 – Application – pp 14 – 51 at pp 36-37
[126] report of Dr Watson dated 7 December 2012 – Application – p 88
[127] Application – p – 265-269
[128] *Wyong Shire Council v Paterson* [2005] NSWCA 74; *Secretary, Department of Family and Community Services v Victoire* [2014] NSWWCCPD 44 at [69]
[129] [2000] HCA 45; 200 CLR 286

224. The respondent submitted that the generally accepted test relating to causation is based on the "commonsense logic" as set out in *Kooragang Cement Pty Ltd v Bates*[130] (*Kooragang*).

225. The respondent submitted that it is not suggested Mr Hallmann suffered an injurious event directly affecting his pelvis or his organs of speech and smell.

226. The respondent submitted that assessment of permanent impairment is made in accordance with s 65 of the 1987 Act; and is assessed by an Approved Medical Specialist in accordance with Part 7 (Medical assessment) of Chapter 7 of the 1998 Act.

227. The respondent, referring to the decision of Deputy President Roche in *Jaffarie v Quality Castings Pty Ltd*[131](*Jaffarie*), submitted that it is the role of the Commission and not the role of an Approved Medical Specialist to determine whether, as a matter of "commonsense and logic", Mr Hallmann's complaints of pain in the pelvis, and alleged problems with smell and speech result "immediately or by an unbroken chain of events, from the relevant event or incident".

228. The respondent submitted that it would be unsafe to rely only on Mr Hallmann's complaints of his problems without medical support; and that the "coincidence of symptoms does not equate to causation"; and the onus is upon Mr Hallmann to establish causation on the balance of probabilities[132].

229. The respondent submitted the opinion provided by Dr Bird in his report dated 8 March 2010: "Due to the nature of the illness, virtually every aspect of the patient's body is affected"[133], is not sufficient to establish causation of the conditions of the pelvis, speech and smell result from the injury.

230. The respondent submitted that Mr Hallmann needs to demonstrate an "actual loss" results from the injury if he claims that the loss results from injury to another part of the body in accordance with the principle of *Department of Public Works v Morrow*[134].

231. The respondent submitted that certain body parts were considered by the Medical Appeal Panel on 9 October 2007 in which "negligible" impairment was found to be present in both legs at or above the knee and the back, and that there was no permanent impairment of brain damage.

Pelvis

232. The respondent submitted that Mr Hallmann equates injury to the pelvis with symptoms in the groin, hips, sacrum and low back, relying on his complaint to Mr Mansen, chiropractor, on 4 November 1996 that "the pain hit my groin and back and I was hunched over", but concedes Mr Manson diagnosed a back strain.

233. The respondent submitted that Mr Hallmann relies upon complaints over time to various medical practitioners that any references to low back, groin, hip, sacrum, and leg pain in the Achilles and right knee support his claim that he suffers with a condition of the pelvis resulting from the injury.

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[130] (1994) 35 NSWLR 452
[131] [2014] NSWWCCPD 79
[132] *Department of Education and Training v Ireland* [2008] NSWWCCPD 134 per President Keating
[133] Application – p 48
[134] (1986) NSWLR 166

234. The respondent submitted, in accordance with the meaning of pelvis as found by Neilson J in *Clymer v Roads & Traffic Authority (NSW)*[135], that references by Mr Hallmann to the legs, groin or low back cannot be found to be references to the pelvis.

235. The respondent submitted Mr Hallmann "has not pointed to any reliable medical evidence that suggests he has suffered injury to his pelvis (including injury to the sacrum, coccyx or hip bones), or whether complaint of referred pain to his pelvis has come from another body part".

236. The respondent submitted that there is no evidence to support Mr Hallmann's proposition that: "the groin pain is associated with the joints, muscles and tendons that join in that region"[136].

237. The respondent submitted the opinion of Dr Bird could not be regarded as reliable because he was reliant on a history provided by Mr Hallmann of pelvic pain some 13 years before he complied his report; and he did not examine or test the pelvis.

238. The respondent submitted Dr Whiting has followed a similar approach to that of Dr Watson, who has "simply cherry picked the pelvis from a constellation of symptoms consistent with ME/CFS".

239. The respondent submitted that Drs Bird, Watson and Whiting have misunderstood the notion of the pelvis because Mr Hallmann "interchangeably referred to his groin and lumbar spine symptoms as being symptoms of his pelvis".

240. The respondent submitted that the first report obtained by Mr Hallmann with respect to permanent impairment assessments of body parts was that of Dr Bird dated 30 June 2005, who did not refer to the pelvis or any alleged impairment of the pelvis; the report being produced approximately nine years after the injury.

241. The respondent submitted Dr Bird provided a number of reports as to permanent impairment assessments of various body parts which were not accepted by the Medical Appeal Panel.

242. The respondent submitted that Dr Bird's findings as set out in his report of 30 June 2005 "is overly-inclusive and overly generous to the applicant in terms of body parts assessed and the levels of impairment assessed yet the pelvis was not included".

243. The respondent submitted that an inference can be drawn by the omission of an assessment of the pelvis by Dr Bird in his report of 30 June 2005 that there was no assessable loss of it.

244. The respondent submitted that while Dr Whiting in his report dated 26 May 2014 said that the pelvis is one of the first areas of pain identified following the onset of the ME/CFS in 1996, he did not refer to any contemporaneous reports and "presumably relied on the flawed history given by Mr Hallmann in which groin and low back complaints were equated to pelvic symptoms".

245. The respondent submitted that while Mr Hallmann reported in 1996 or at other times in the late 1990's to treatment providers that the pain affected his lower back and groin, there is "almost total absence of specific complaints about the pelvis".

[135] (1996) 13 NSWCCR 187
[136] Applicant's written submissions dated 10 July 2015 at p 28

246. The respondent submitted that Mr Hallmann does not point to any history of specific recorded symptoms in the "actual pelvis" until Dr Bird started providing permanent impairment assessments for him in May 2010 in circumstances where the "wide-ranging" report of Dr Bird dated 30 June 2005 did not include an assessment of permanent impairment of the pelvis.

247. The respondent submitted that Mr Hallmann answered a question in the negative in respect of a history form provided to Mr Mansen on 4 November 1996 of "pain in the right groin, hip, back and Achilles" was "job related" or "workers comp".

248. The respondent submitted that Mr Hallmann never gave Mr Mansen the history of "Hip out in 1988, 1991 – corrected with chiropractic treatment" to Drs Bird, Watson and Whiting or its independent medical experts, Drs Slezak and Potter, and Prof Wakefield.

249. The respondent submitted that the isolated complaints of hip symptoms to Mr Mansen in November 1996 and Dr Pacey in May 1997 could "just plausibly resulted from the pre-existing hip condition which had necessitated prior chiropractic treatment in1988 and 1991".

250. The respondent submitted that Drs Bird, Watson and Whiting did not have a fair climate[137] upon which to base their opinions as to the causation of the hip pain resulting from the injury.

251. The respondent submitted that while Dr Bird provided a report in March 2010 assessing permanent impairment of the pelvis on the basis of chronic pelvic pain which he said was associated with CFS, pelvic pain was not mentioned in his earlier 2005 report.

252. The respondent submitted that the alleged pelvic symptoms "seem to have first emerged in earnest in about 2010, approximately fourteen years after the onset of the applicant's ME/CFS conditions by which he was aged in his early 40s".

253. The respondent submitted that the onset of the pelvic symptoms in 2010 could be explained by the development of early osteoarthritis in the hips or by recurrence of the pre-existing mechanical hip issues which required chiropractic treatment in 1998 and 1991.

254. The respondent submitted that none of Mr Hallmann's doctors had considered a possible alternative diagnosis of osteoarthritis or other non-work pre-existing or subsequently developing conditions or referral for x-rays to explore the possibility of an alternative diagnosis.

255. The respondent submitted that Mr Hallmann's doctors have not kept an open mind in relation to possible alternative explanations for some of his symptoms, but have included symptoms and body parts on a "global basis" that they "must have resulted from ME/CFS condition without any proper analysis or proper investigations or reasons".

256. The respondent submitted that the opinions of Drs Bird, Watson and Whiting on the question of causation of the pelvis symptoms as a result of the injury are speculative and do not constitute probative evidence as laid down in *Sydney Area Health Service v Edmonds*[138].

257. The respondent submitted that the reference to "anteriorly tilted pelvis" in the report of Mr Darren Glendenning dated 14 December 2000 attached to an Application to Admit Late Documents filed on 15 July 2015 should be ignored because it was filed after the fifth arbitration hearing and after the commencement of the parties' submissions.

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[137] *Paric v John Holland (Constructions) Pty Ltd* [1985] HCA 58; 62 ALR 85; 59 ALJR 844 referred to by Keating P in *O v Nepean Blue Mountains Local. Health District* [2014] NSWWCCPD 52; *Makita (Australia) Pty Limited v Sprowles* [2001] NSWCA 305 at [64] and *Hevi Lift (PNG) Ltd v Etherington* [2005] NSWCA 42 at [80-86]

[138] [2007] NSWCA 16 at [127]-[140]

258. The respondent submitted that if the report of Mr Glendenning is admitted into evidence then the reference to "anteriorly tilted pelvis" was a

> "mere reference to the applicant's posture at a moment in time and did not demonstrate any pain or pathology in his pelvis and appears to have been connected with poor abdominal tone and posture, which are both commonplace (particularly in overweight, middle-aged people) in the community".

259. The respondent submitted that Drs Bird and Whiting when describing the complaint as "severe back pain" meant it was the back and not the pelvis.

260. The respondent submitted that it was unlikely Dr Watson omitted reference to the pelvis when assessing permanent impairment of body parts as set out in his report of 22 December 2012.

261. The respondent submitted that Mr Hallmann's complaints of symptoms in the groin and lower back "somehow represented pelvic symptoms" should be rejected as being self-serving, implausible and contrary to commonsense.

Loss of sense of smell

262. The respondent submitted there is no evidence to suggest Mr Hallmann is unable, or has a reduced ability, to detect any scents.

263. The respondent submitted to the contrary, Mr Hallmann complains his sense of smell is heightened, although he allegedly has a nasal drip.

264. The respondent submitted there has been no testing by an expert specialist to establish any loss of smell resulting from the claim by Mr Hallmann of hypersensitivity or other nasal symptoms.

265. The respondent submitted Drs Bird, Watson and Whiting are unqualified because they have no expertise in ear, nose and throat medicine, and their opinions in support of Mr Hallmann's alleged condition affecting his olfactory system and sense of smell should be rejected.

266. The respondent submitted Mr Hallmann has not discharged his onus that he suffers with a pathological condition in respect of his olfactory system/sense of smell as a result of his injury.

Loss of power of speech

267. The respondent submitted there is no probative or plausible evidence to suggest Mr Hallmann is restricted in his ability to form words or utter them.

268. The respondent, in support of this submission, referred to the decision of Burke CCJ in *Ivanovic v State Rail Authority (NSW)*[139].

269. The respondent submitted Mr Hallmann relies upon the opinion of Dr Whiting[140], who included dysphasia and aphasia in a list of symptoms associated with a test for brain damage along with poor concentration and altered processing speed amongst other cerebral dysfunction as the cause of his loss of power of speech, but the Medical Appeal Panel in 2007 assessed permanent impairment of brain damage at 0%.

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[139] (1998) 16 NSWCCR 277

[140] report of Dr Whiting dated 25 May 2014 – Application – p 1260

270. The respondent submitted that the Commission should reject Mr Hallmann's submissions that the transcripts of the arbitration proceedings record his alleged speech deficits demonstrated by some simplistic statistics, which is self-serving sophistry, because he was unfamiliar with the procedure of conducting an oral hearing as an advocate, at times, uttering things to himself, and positioning his head close to his laptop affecting the transmission of his voice to the microphones.

271. The respondent submitted Mr Hallmann demonstrated his ability to speak with great conviction and at times with anger, and in a loud and clear voice at the arbitration hearing and during six telephone conferences with the Arbitrator.

272. The respondent submitted that Mr Hallmann's speech condition is supported by his "three advocate doctors" – Drs Bird, Watson and Whiting, and their opinions should be disregarded as they have nil or very little evidentiary, probative or persuasive value because they have become advocates in his cause.

273. The respondent submitted the opinion of Prof Wakefield should be preferred to the opinions of Drs Whiting, Watson and Bird to the extent of any inconsistencies between his opinion and the opinions of Mr Hallmann's advocate doctors.

274. The respondent submitted the findings of Prof Wakefield that he detected no evidence of dysphasia and aphasia when he assessed Mr Hallmann, although he noted Mr Hallmann had trouble remembering words, should be accepted.

275. The respondent submitted that while Prof Wakefield thought there was evidence of some cognitive impairments related to CFS, his opinion that it was overstating the case to classify them as dysphasia and aphasia should be accepted[141].
276. The respondent submitted that Mr Hallmann has not discharged his onus of proof of establishing that the claim for alleged loss of speech results from the injury.

277. In conclusion, the respondent submitted that the claims for the pelvis based upon complaints of groin, back and leg pain cannot be accepted as establishing a claim for pelvic pathology or impairment; complaints of confused thought processes cannot be accepted as establishing a claim for a loss of power of speech; and that complaints of post nasal drip or sinusitis cannot be accepted as establishing a claim for loss of smell or pathological change to the olfactory system.

278. The respondent submitted Mr Hallmann has not established on the balance of probabilities that he suffers with conditions of the pelvis, loss of power of speech and loss of sense of smell as a result of his injury deemed to have occurred on 29 November 1996.

Discussion

279. I agree with the respondent's submission, in accordance with the principle of *Jaffarie*, that it is the role of the Commission to determine questions of causation.

280. Deputy President Roche in *Jaffarie* at [249]-[250] set out the principles applying to proceedings in the Commission:

> "249. Notwithstanding the different approach by Emmett JA and Meagher JA, it is my view that the following principles apply to proceedings in the Commission:

[141] report of Prof Wakefield dated 30 September 2013 – Reply – pp 449 – 468 at p 457 and p 459

(a) questions of causation are not foreign to medical disputes within the meaning of that term when used in the 1998 Act. Assessing the degree of permanent impairment 'as a result of an injury', and whether any proportion of permanent impairment is 'due' to any previous injury or pre-existing condition or abnormality, both call for a determination of a causal connection (*Bindah* at [110]);

(b) it is for the Commission to determine whether a worker has received an injury within the meaning of s 4 of the 1987 Act and whether there are disentitling provisions, such that compensation is not payable for that injury (*Bindah* at [111] and s 105 of the 1998 Act;

(c) the Commission's jurisdiction is restricted by s 65(3) of the 1987 Act, which precludes the Commission (an Arbitrator or Presidential member) from awarding permanent impairment if there is a dispute about the degree of permanent impairment, unless the degree of impairment has been assessed by an AMS (*Bindah* at [111]);

(d) the determination of the degree of permanent impairment that results from an injury is a matter wholly within the jurisdiction of the AMS or, on appeal, the Appeal Panel and is not a matter for determination by an Arbitrator (*Bindah* at [112]);

(e) a finding made by a person without jurisdiction cannot bind a person or persons who have jurisdiction (*Haroun* at [16] and [19]-[21], and

(f) it is desirable to avoid drawing a rigid distinction between jurisdiction to decide issues of liability and jurisdiction to decide medical issues (*Bindah* at [110]; *Tolevski* at [35]).

250. This means that, to the extent that it held that all matters of causation are exclusively within the jurisdiction of the Commission, Peric cannot stand with *Binda, Tolevski* and *Austin*…. That is because, in a claim for lump sum compensation, the physical consequences of the injury (in relation to the assessment of whole person impairment as a result of the injury) are not within the exclusive jurisdiction of the Commission. They are within the exclusive jurisdiction of the AMS. That is so even if the matter also involves a disputed claim for weekly compensation and disputes about causation, which the Commission has determined."

281. There is no dispute that Mr Hallmann suffers with the conditions of ME/CFS with persisting FM as a result of injury arising out of or in the course of his employment with the injury deemed to have happened on 29 November 1996.

282. The respondent accepts that Mr Hallmann suffers with the following conditions resulting from the ME/CFS with persisting FM as a result of the injury, entitling determination of the degree of permanent impairment by an Approved Medical Specialist under the Table of Disabilities, in respect of the following losses:

(a) brain damage;
(b) neck;
(c) back;
(d) bowel function;

(e) hearing;
(f) right arm;
(g) left arm;
(h) right leg;
(i) left leg;
(j) sexual organs, and
(k) sight of both eyes.

283. The respondent disputes that the pelvis, speech and smell are conditions of ME/CFS with persisting FM as a result of the injury.

284. The respondent relies upon the opinion of Prof Wakefield to dispute liability that the alleged conditions of the pelvis, speech and smell result from the injury.

285. I agree with the respondent's submission that the question of causation of injury is solely within the jurisdiction of the Commission.

286. The question of causation in common law and workers compensation is a "commonsense test": *Kooragang*; *March v Stramare (E & MH) Pty Ltd*[142] and *Sarkis v Summitt Broadway Pty Ltd t/as Sydney City Mitsubishi*[143].

287. The commonsense test of causation in workers compensation was considered by Kirby P in *Kooragang*. His Honour at [463]-[464] said:

> "The result of the cases is that each case where causation is in issue in a worker's 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 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 commonsense 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 of compensation."

288. In *Zinc Corporation v Scarce*[144], Clarke JA said:

> "It is now well established at common law that the test of causation is a common sense one. Any controversy on the question has been laid to rest by the decision of the High Court in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506. What needs to be established is that the event which is sought to be linked with injury 'was so connected with the loss or injury that, as a matter of ordinary common sense and experience, it should be regarded as a cause of it'. (See *Halvorsen Boats Pty Ltd v Robinson* (1993) 31 NSWLR 1 at 7). The question is, of course, a question of fact which 'must be determined by applying common sense to the facts of each particular case' (see *March* at 15). In my opinion, there is no reason to adopt a different approach in relation to the test of causation posed by the words 'arising out of'. The question of fact is whether there is such a connection between the worker's personal injury and his employment that, as a matter of ordinary common sense and experience, the injury should be regarded as having arisen out of that employment. In deciding that question, my preferred view is that the test laid down by Jordan CJ in *Nunan*

[142] (1991) 171 CLR 506
[143] [2006] NSWCA 358
[144] (1995) 12 NSWCCR 566 at 570

v Cockatoo Docks & Engineering Co Ltd (1941) 41 SR (NSW) 119 at 124 – that the fact of his being employed in the particular job caused, or to some material extent contributed to, the injury – should be applied. At the very least, the test requires that the employment was a contributing factor to the injury (an expression to be found in section 6(a) and section 6(b))."

289. The term "arising out of" involves a causal element and is to be inferred from the facts as a matter of commonsense: *Badawi v Nexon Asia Pacific Pty Limited t/as Commander Australia Pty Ltd*[145].

290. Starke J in *Smith v The Australian Woollen Mills Limited*[146] when considering the expression "arising out of" said:

> "The expression 'arising out of' imports some kind of causal relation with the employment, but it does not necessitate direct or physical causation. Was it part of the injured person's employment to hazard, to suffer, or to do that which caused his injury? It must arise out of the work which the worker is employed to do – out of his service."

291. President Keating considered the meaning of "arising out of employment" in *Van Wessem v Entertainment Outlet Pty Ltd*[147]:

> "The phrase 'arising in the course of employment' refers to temporal relationship between the injuries and the employment. A causal connection is only relevant to injuries arising 'out of' the employment."

292. Deputy President Roche considered the meaning of "arising out of" in *Qantas Airways Ltd v Watson (No 2)*[148]:

> "As observed in *Badawi v Nexon Asia Pacific Pty Ltd,* the meaning of 'arising out of … employment' is settled. The majority in *Badawi* referred to and endorsed the approach in *Nunan v Cockatoo Island Docks & Engineering Co Ltd* (1941) 41 SR (NSW) 119, where the court 'adopted a commonsense approach to the application of the phrase, noting that it involved a causative element'."

293. In my view, what is required is a commonsense evaluation of the causal chain or a causative element to establish if the conditions of the pelvis, speech and smell result from the injury (ME/CFS with persisting FM).

294. I agree with the respondent's submission that the onus of proof is upon Mr Hallmann to establish on the balance of probabilities that he suffers with the conditions of the pelvis, loss of power of speech and loss of sense of smell, and that they are conditions or symptoms of MC/CFS with persisting FM; and that there is an unbroken causal link or chain between the conditions and the injury.

295. In *Department of Education and Training v Ireland*[149]*,* President Keating, considered the principles relevant to the discharge of the onus of proof citing a number of authorities.

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145 [2009] NSWCA 324; 6 DDCR 75
146 (1933) 50 CLR 504 at 517
147 [2010] NSWWCCPD 97 at [99]
148 [2010] NSWWCCPD 38 at [76]
149 [2008] NSWWCCPD 134 at [88]-[90]

296. The meaning of onus of proof was considered and discussed by the Court of Appeal in *Nguyen v Cosmopolitan Homes*[150]. McDougall J (McColl and Bell JJA agreeing) said:

> "44. A number of cases, of high authority, insist that for a tribunal of fact to be satisfied, on the balance of probabilities, of the existence of a fact, it must feel an actual persuasion of the existence of that fact. See Dixon J in *Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336. His Honour's statement was approved by the majority (Dixon, Evatt and McTiernan JJ) in *Helton v Allen* [1940] HCA 20; (1940) 63 CLR 691 at 712.
>
> 45. Dixon CJ put the matter in different words, although to similar effect, in *Jones v Dunkel* [1959] HCA 8; (1959) 101 CLR 298 at 305 where his Honour said that '[t]he facts proved must form a reasonable basis for a definite conclusion affirmatively drawn of the truth of which the tribunal of fact may reasonably be satisfied'. Although his Honour dissented in the outcome of that case, the words that I have quoted were cited with approval by the majority (Stephen, Mason, Aickin and Wilson JJ) in *West v Government Insurance Office of NSW* [1981] HCA 38; (1981) 148 CLR 62 at 66. See also Stephen J in *Girlock (Sales) Pty Limited v Hurrell* [1982] HCA 15; (1982) 149 CLR 155 at 161-162, and Mason J (with whom Brennan J agreed) in the same case at 168.
>
> 46. It is clear, in particular from *West* and *Girlock*, that the requirement for actual satisfaction as to the occurrence or existence of a fact is one of general application, and not limited to cases where the fact in question, if found, might reflect adversely on the character of a party or witness.
>
> 47. In *Malec v JC Hutton Pty Limited* [1990] HCA 20; (1990) 169 CLR 638 Deane, Gaudron and McHugh JJ said at 642-643:
>
> > 'A common law court determines on the balance of probabilities whether an event has occurred. If the probability of the event having occurred is greater than it not having occurred, the occurrence of event is treated as certain; if the probability of it having occurred is less than it not having occurred, it is treated as not having occurred.'
>
> 48. On analysis, I think, what their Honours said is not inconsistent with the requirement that the tribunal of fact be actually persuaded of the occurrence or existence of the fact before it can be found. On their Honours' approach, what is required is a determination of the respective probabilities of the event's having occurred or not occurred. There is nothing in that analysis to suggest that the determination in favour of probability of occurrence should not require some sense of actual persuasion."

[150] [2208] NSWCA 246 at [44]-[48]

297. The respondent submitted that the opinions of Drs Bird, Watson and Whiting have no probative weight because they have lost their objectivity and impartiality as they are either Mr Hallmann's advocates or have become advocates in his cause; merely accepting his complaints about the pelvis, speech and smell as part of his constellation of symptoms and assuming without applying any "intellectual rigour" that the symptoms complained of are criteria of ME/CFS with persisting FM.

298. While the respondent submitted the opinions of Drs Bird, Watson and Whiting have no probative weight because of the lack of objectivity and impartiality, no submission was made that they are not forensic experts in their fields of speciality.

299. Dr Bird has been Mr Hallmann's general practitioner since 2003. Dr Bird has an interest in the medical conditions of ME/CFS and FM, specialising in the treatment of persons suffering with these conditions.

300. Dr Bird said in his report dated 8 March 2010 that he has been Mr Hallmann's general practitioner for the past six years; and during that time Mr Hallmann has "proven to be a very credible reporter of symptoms and history". Dr Bird said[151]:

> "In particular his reported symptoms have at times later been supported by objective evidence which has presented itself at a later date. He is open and honest about his activities (e.g. Baseball, Cricket and Exercise physiology), expectations, commitment to management and the illness experience."

301. Dr Watson, whose field of speciality is rehabilitation medicine, has been treating Mr Hallmann since 2007 for his conditions of ME/CFS with persisting FM.

302. Dr Watson acknowledges that he has not undertaken research in this area of medicine but said he has a specific interest in CFS and FM, their relationship and potential impingement upon the area of chronic pain, the management of which is his speciality, and has written a number of detailed reports with respect to Mr Hallmann after undertaking thorough examinations of him[152] over the years.

303. Dr Whiting, whose field of speciality is internal medicine and infectious diseases, has been treating Mr Hallmann since December 2011 on referral from Dr Bird for his conditions of ME/CFS and FM. Dr Whiting has extensive experience in the fields of ME/CFS and FM with over 20 years of experience in a clinical setting. He has also published papers to the medical profession on these conditions[153].

Background

304. This is a summary only of the onset of symptoms and relevant investigations undertaken to diagnose ME/CFS with persisting FM; and does not include every investigation, consultations with medical providers and the chronicity or multitude of investigations and treatment provided to Mr Hallmann over the years since the onset of his symptoms.

305. In 1992, within days of commencing employment with the respondent, Mr Hallmann experienced an illness consistent with an infectious origin which was diagnosed clinically and serologically as infectious mononucleosis (Glandular Fever/Epstein-Barr Viral Disease).

306. In 1994, Mr Hallmann reported the onset of sinus symptoms.

307. In 1995, Mr Hallmann reported flu like symptoms.

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[151] Application – p 17
[152] Application – p 106
[153] supra – p 689

308. In 1996, Mr Hallmann had a series of flu like illness that were diagnosed and treated as Bronchial asthma.

309. On 23 July 1997, Mr Hallmann attended upon Mr Downs, physiotherapist, for low back pain, which he reported as having its onset in mid-October 1996[154]

310. In late 1996, Mr Hallmann woke with pain in the right groin, right upper leg and low back[155].

311. On 4 November 1996, Mr Hallmann attended upon Mr Neil Manson, chiropractor, at the Stevenson Chiropractic Clinic for treatment of his "groin, hip, low back and Achilles tendon"[156].

312. The patient record of the Stevenson Chiropractic Clinic in respect of Mr Hallmann's attendance on 4 November 1996 records his complaints as follows[157]:

> "fatigue", "low back pain", "joint pain/stiffness" "walking problems" "currently has a bit of pain in the right groin & hip, some back pain and Achilles Problems."

313. On 29 November 1996, Mr Hallmann was unable to attend work because of pain which he said: "hit me firmly in the lower back and groin"[158].

314. In 1996 and 1997 Mr Hallmann underwent special investigations in the form of x-rays, CT and MRI scans.

315. In May 1997, Mr Hallmann, at the request of the respondent, attended upon Dr Sage, orthopaedic surgeon, for assessment.

316. Dr Watson reported that Dr Sage wrote: "lethargy and bizarre symptoms", noting the radiating nature of the pain in the muscles[159].

317. Dr Watson is of the opinion that the "documents" provided to him, demonstrate the onset of the condition of ME/CFS was in 1996, and that the sudden nature of the onset on 29 November 1996, in his opinion, was "self-evident when one takes into account the criteria applicable for ME/CFS being the 1994 CDC Criteria (Fukuda et al) and the 2003 Consensus Criteria (Carruthers et al)".[160]

318. In April 1998, Mr Hallmann was diagnosed with CFS by Dr Helen Willoughby, confirmed by Dr Ian Stewart, respiratory physician, who found he also suffered with the overlapping condition of FM.

319. In 1998, Mr Hallmann was tested for various pathogens which demonstrated that he had mycoplasma mosorei and fermentans and Rickettsia australis consistent with ME/CFS.

320. In late 1998, Mr Hallmann underwent a Tilt table test which was positive to Postural Osthostatic Tachycardia Syndrome (POTTS).

321. In 1998, 1999 and 2000, Mr Hallmann underwent "Bioscreen" tests; the results were found to be consistent with ME/CFS

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[154] report of Chris Downs dated 11 August 1997 – Reply – pp 20-21
[155] report of Dr Watson dated 7 December 2012 – Application – p 70
[156] report of Neil Manson dated 26 February 1999 – Application to Admit Late Documents dated 10 July 2015
[157] Application – pp 1724-1725
[158] Application to Admit Late Documents filed on 18 February 2015 – "History of the Condition" – p 46
[159] Application – p 71
[160] supra – p 71

322. In 1999/2000 and 2009, Mr Hallmann underwent psychological testing by Dr King, clinical psychologist, which revealed, in Dr Watson's opinion, issues with Mr Hallmann's IQ and processing speed; also, consistent with his symptoms and indicia of brain dysfunction.

323. In 2000, Mr Hallmann underwent RNAse L testing, which showed he had a dysregulation of the 2-5A Synthetase/RNAse L anti-viral pathway, consistent with ME/CFS.

324. In 2001, Mr Hallmann underwent a Holter monitor which showed mild tachycardia consistent, in Dr Watson's opinion, with complaints of faintness and palpitations.

325. In 2001, Mr Hallmann underwent an qEEG brain topography revealing there was an abnormality, similar, in Dr Watson's opinion, to the condition of ADHD, and consistent with ME/CFS.

326. Dr Whiting concluded that the psychological testing and qEEG indicated serious issues with respect to brain activity consistent with ME/CFS.

327. Mr Hallmann has undergone pathological investigations.

328. Mr Hallmann has undergone a plethora of investigations since the diagnosis of his ME/CFS in April 1998 by Dr Willoughby, too numerous to be set out, but referred to by Drs Watson and Whiting in their multiple reports to support their diagnosis of ME/CFS with the overlap of FM.

329. Dr Watson referred to the diagnostic evidence in his report dated 7 December 2012 upon which he reached his conclusion that Mr Hallmann suffers with ME/CFS and FM[161].

330. Dr Watson in the same report set out the symptoms which Mr Hallmann has been suffering with since 1996[162]:

> "1. Fatigue (static and post-exertional)
>
> 2. Pain (static and post-exertional)
>
> 3. Disturbed neurocognitive function
>
> 4. Reduced physical ability
>
> 5. Multiple widespread sensory and bodily system dysfunctions."

331. In respect of "pain", Dr Watson said[163]:

> "Pain is variable in intensity and nature, but in some degree, is constantly present. He rates his static pain at 3/10. He notes that this can escalate to 7/10 following exercise and higher following significant exertion. He breaks his pain into three types being total body pain, joint pain and pain at specific sites. It is also variable in its widespread distribution but always at multiple sites. Visual recording of these sites in the several Brief Pain Inventories carried out over the six years that I have been involved in this case, are included for your information. In quality, it varies from a dull to a deep ache, to jabbing, lancinating, electric-like shooting pains to burning sensation with the latter being a very prominent feature. Spasm at multiple levels of the body occurs regularly but unpredictably and is always associated with a general increase, but also a local increase of pain at the site of spasm.

[161] Application – pp 78-84
[162] report of Dr Watson dated 7 December 2012 – Application – p 85
[163] supra – p 86-87

> Associated with the pain is often numbness or tingling. On each occasion when seen he has shown exquisite tenderness of the established fibromyalgic trigger points, but also a more generalised deep pressure hypersensitivity, particularly in the areas where he is prone to spasm. I have recently viewed an involuntary spasm during my examination in which he had an involuntary reaction from the abdominal palpation which caused spasm of the thoracic paraspinal muscles. He complained also on a number of pains in the back that progressed to spasm as he was on the examination table…."

332. Dr Watson said that pain has been a major feature of the clinical syndrome as have been variable sensory disturbances, consistent with the diagnosis of FM which is accepted as a common co-morbidity overlapping with ME/CFS[164].

333. Dr Watson also said that the widespread sensory disturbance suggests a central neuropathic disturbance rather than nerve root or peripheral nerve involvement, consistent with the basic pathophysiology of FM.

334. In respect of cognitive function, Dr Watson said[165]:

> "***Cognitive Function*** – Disturbed cognitive function manifests in many ways, but particularly his inability to concentrate, short term memory issues, processing speed, organisation and retention of material. Its presence varies and is not predictable except when he engages in exercise or significant activity. In such cases it is always precipitated or accentuated with deteriorating fatigue and pain is frequently associated under these circumstances with mumbling verbalisation and difficulty in word finding. The 'numbing of his brain' has been a significant factor in the extended period required for his academic achievements and the need for positive discrimination by his examining institutes. It is noted that between 2006 and 2011 he has attempted six units in a Graduate certificate and he has failed five of those units."

335. Mr Hallmann has also undergone extensive physiotherapy and chiropractic treatment since 1997 to 2001 with a break until 2004, and then resumed.

336. In April 2012, Dr Whiting requested a SPECT scan of the brain which revealed significant reduction of blood flow to the brain, consistent with ME/CFS, which correlated with the positive Tilt Table test and assertions of brain damage/dysfunction as found by Dr King[166].

337. Dr Whiting said that the SPCT scan revealed quite marked deficits in cerebral perfusion or focal glucose uptake in various cortical and subcritical areas of grey matter, and that such results are consistent with MC/CFS research and reflective of a brain function injury[167].

338. The SPECT scan was repeated in February 2013.

339. Dr Whiting said that cerebral blood flow abnormalities as revealed by the SPECT scans are a feature of "neutrally mediated hypotension" consistent with ME/CFS[168].

340. Mr Hallmann has been prescribed numerous medications for his ME/CFS, including vitamin supplements.

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[164] supra – p 104
[165] supra – p 87
[166] report of Dr Watson dated 22 December 2012 – Application – p 123
[167] report of Dr Whiting dated 26 May 2014 – Application – p 1164
[168] report of Dr Whiting dated 24 March 2013 – Application – p 436

341. Dr Watson said that FM and CFS commonly run together, and that the applicable criteria for FM is the 1990 American College of Rheumatology criteria which states[169]:

> "1. History of widespread pain has been present for at least three months;
>
> 2. Pain is considered widespread when all of the following are present:
>
> - Pain in both sides of the body
> - Pain above and below the waist. In addition, axial skeletal pain (cervical spine anterior chest, thoracic spine or low back pain) must be present. Low back pain is considered lower segment pain.
> - Pain in 11 of 18 tender point sites on digital palpation
> - Definition: Pain, on digital palpation, must be present in at least 11 of the following 18 tender point sites:
>
> - Occiput – (2) – at the suboccipital muscle insertions.
> - Low cervical (2) – at the anterior aspects of the intertransverse spaces at C5-C7
> - Trapezius (2) – at the midpoint of the upper body.
> - Supraspinatus (2) – at origins, above the scapula spine near the medial border.
> - Second rib (2) – upper, lateral to the second costochondral junction.
> - Lateral epicondyle (2) – 2 cm distal to the epicondyles.
> - Gluteal (2) – in upper outer quadrants of buttocks in the anterior fold of muscle.
> - Greater trochanter (2) – posterior to the trochanteric prominence.
> - Knee (2) – at the medial fat pad proximal to the joint line
>
> Digital palpation should be performed with an approximate force of 4 kg. A tender pint has to be painful at palpation, not just 'tender'."

342. Drs Watson and Whiting concluded on their review of the medical evidence, the results of the numerous investigations and their evaluation of Mr Hallmann's symptoms, that his symptoms satisfied the criteria for ME/CFS, in accordance with the 1995 CDC and 2003 Canadian Consensus, and the criteria for FM (North American definition), which overlaps the ME/CFS.

Respondent's medical assessments

343. On 17 September 1999, Mr Hallmann was assessed by Dr Sutherland, clinical immunologist and consultant physician. Mr Hallmann was subsequently assessed by Dr Sutherland on 1 October 1999 and again on 14 October 2002.

344. Dr Sutherland said that on the three occasions he assessed Mr Hallmann he found "no evidence of any physical or intellectual disability"[170].

345. On 2 September 2002, Mr Hallmann was assessed by Dr Lee, psychiatrist.

[169] report of Dr Watson dated 7 December 2012 – Application – pp 100-101
[170] report of Dr Sutherland dated 9 December 2002 – Reply – p 24

346. On 13 October 2004, Mr Hallmann was assessed by Mr Ross Baines, physiotherapist, for the purpose of providing an opinion whether physiotherapy treatment was reasonably necessary as a result of injury.
347. Mr Baines described Mr Hallmann's complaints as "variable and diffuse muscular pain and spasms", and "some central low back pain and cervico thoracic pain"[171]. Mr Baines considered that physiotherapy treatment was not reasonably necessary as a result of injury.

348. On 3 November 2004, Mr Hallmann was assessed by Dr Robert King, consultant physician in internal medicine. Dr King considered there were a number of inconsistencies but found the symptoms were consistent with a diagnosis of CFS, although he could not rule out the possibility of other aetiological factors such as Addison's disease[172].

349. On 29 November 2004, Mr Hallmann was assessed by Dr Oakeshott, orthopaedic surgeon. Dr Oakeshott was unable to identify "any objective clinical evidence of any physical injury or underlying pathology in any part of his body"; and "he does not have any objective clinical evidence of any musculo-ligamentous injury or condition or any physical injury or condition which would account for his alleged symptoms"[173]. Dr Oakeshott acknowledged he is not an expert in the field of ME/CFS.

350. On 10 August 2006, Mr Hallmann was assessed by Dr Slezak.

351. Mr Hallmann complained to Dr Slezak of "widespread muscle(s) and muscle spasm, widespread arthralgia(s)"[174].

352. Dr Slezak considered Mr Hallmann to be suffering with a somatoform disorder, which would mitigate against a diagnosis of CFS. Dr Slezak disagreed with the "assumption of a diagnosis of chronic fatigue syndrome"[175].

353. On 20 September 2010, Mr Hallmann was again assessed by Dr Slezak. Mr Hallmann complained of pain throughout his body with "tender points" over the neck and both upper limbs. Dr Slezak did not consider Mr Hallmann "to continue to suffer with the condition of 'myalgic encephalomyelitis/chronic fatigue syndrome/fibromyalgia' on the basis of history/clinical examination"[176].

354. On 27 July 2011, Mr Hallmann was assessed by Dr Stephen Potter, rheumatologist. Dr Potter reported that Mr Hallmann presented with a "multiple unexplained symptoms, that is, in every bodily part he has a symptom"[177]. Dr Potter considered that if there were to be speculation of injury, it would be "seen in psychological and psychiatric symptom profile". Dr Potter diagnosed "chronic widespread pain/overlapped with somatoform complaints. No physical injury".

355. On 26 November 2011, Mr Hallmann was assessed by Dr Brian Potter, psychiatrist.

356. On 14 December 2011, Mr Hallmann was seen by Mr Greg Schneider, physiotherapist, for the purpose of assessing whether physiotherapy treatment was reasonably necessary as a result of the injury.

357. On 30 November 2012, Mr Hallmann was assessed by Prof Wakefield.

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[171] report of Ross Baines dated 13 October 2004 – Reply p 114
[172] report of Dr King dated 5 November 2004 – Reply – p 130
[173] report of Dr Oakeshott dated 29 November 2004 – Reply – p 21
[174] report of Dr Slezak dated 21 August 20-06 – Reply p 136
[175] supra – p 139
[176] report of Dr Slezak dated 24 September 2010 – p 170
[177] report of Dr Stephen Potter dated 3 August 2011 – Reply p 177

358. Prof Wakefield, whose field of speciality is Immunopathology and CFS, diagnosed Mr Hallmann to be suffering with "mild chronic fatigue syndrome, fibromyalgia, possible obstructive sleep apnoea, abnormal stress reaction and intermittent depression"[178].
359. On 20 September 2013, Prof Wakefield reviewed Mr Hallmann. Prof Wakefield found that Mr Hallmann "continues to suffer from chronic fatigue syndrome with associated fibromyalgia" and obstructive sleep apnoea, and that "CFS is not curable"[179].

Findings

360. Dr Bird, who has been Mr Hallmann's general practitioner since 2004, said that Mr Hallmann's reported symptoms have at times later been supported by objective evidence, which has presented itself at a later date[180]. Dr Bird assessed Mr Hallmann to be suffering with permanent impairment of the pelvis, speech and smell.

361. The respondent was critical of Dr Bird's assessment because he did not set out the losses for the pelvis, sense of smell and power of speech in accordance with the Table of Disabilities. The criticism was based upon the fact that Dr Bird did not understand the jurisdiction in New South Wales because he practises medicine interstate. The respondent does not object to incorrect descriptors by Dr Bird of other losses under the Table of Disabilities which it has agreed can be referred to an Approved Medical Expert for assessment of permanent impairment.

362. The respondent submitted that while Dr Bird provided assessments of various losses in his report dated 30 June 2005, he did not provide an assessment of the pelvis, smell and speech, and it would be expected that those losses would have been included if there had been complaints about them at that time.

363. The inference the respondent seeks to draw by the omission of the pelvis, smell and speech in Dr Bird's report of 30 June 2005 is that these symptoms or conditions were either not complained about by Mr Hallmann or those conditions of which he complains about did not exist at that time, or he merely accepted later complaints as part of the constellation of complaints by Mr Hallmann without further investigation.

364. The respondent submitted that no probative weight can be given to the opinions of Drs Bird, Watson and Whiting because they have become advocates in Mr Hallmann's cause; have lost their objectivity and impartiality, and failed to comply with Direction 3 issued by the Commission, and r 14(3) of the 2011 Rules.

Pelvis

365. Mr Hallmann submitted that a historical review of the documentary evidence establishes the onset of the ME/CFS with persisting FM occurred in October 1996, and that the symptoms began in the right Achilles, progressed to the right knee into the right groin, then the right hip and the sacroiliac joint, and then progressed throughout the body.

366. In support of this submission, Mr Hallmann referred to his complaints to various medical providers as set out in paragraph 185, and the various special investigations undertaken as set put at paragraph 193, and complaints to joints and body parts as set out at paragraph 195.

[178] report of Prof Wakefield dated 30 November 2012 – Reply – p 391
[179] report of Prof Wakefield dated 24 November 2014 – Application to Admit Late Documents filed by the respondent on 25 November 2014 – p 137
[180] report of Dr Bird dated 8 March 2010 – Application – p 19

367. I accept Mr Hallmann complained about “low back pain”, “joint pain/stiffness”. “pain in the right groin & hip, some back pain and Achilles problems” when he consulted Mr Mansen, chiropractor, on 4 November 1996.

368. It was not until April 1998 that the diagnosis of ME/CFS with overlapping or the comorbid condition of FM was made by Dr Willoughby, confirmed by Dr Stewart.
369. Mr Hallmann had undergone multiple investigations and treatment by physiotherapists, chiropractors and medical providers to establish the cause of his complaints before ME/CFS with overlapping FM was diagnosed by Dr Willoughby.

370. Dr Watson said that fatigue (static and post-exertional) and pain (static and post-exertional pain) and multiple widespread sensory and bodily system dysfunctions are symptoms of ME/CFS with persisting FM[181], and that pain is variable in intensity and nature, but in some degree is constantly present consisting of body pain, joint pain and pain at specific sites; and that the pain varies from a dull to deep ache, to jabbing, lancinating, electric type shooting pains to a burning sensation with the latter being a very prominent, and exquisite tenderness over “established fibromyalgic trigger points”, which he has witnessed since treating Mr Hallmann.

371. Dr Watson said that when he first saw Mr Hallmann in 2007, he demonstrated a cutaneous neurological disturbance consistent with a central neuropathic problem.

372. Dr Watson opined that the history of widespread pain to Mr Hallmann’s body, including joint pain, satisfied 11 of the 18 tender points to establish a diagnosis of FM in accordance with the 1990 American College of Rheumatology Criteria[182].

373. Dr Watson opined that ME/CFS is a “multi-system condition that effects the body with pain and fatigue” and impacts upon almost all of the body systems”[183].

374. Dr Watson said that spinal complaints including the cervical, thoracic, lumbar and pelvic as well as fatigue, pain, weakness and muscle tightness/spasm are derived symptoms and “arise as a direct result of ME/CFS with overlapping FM, which are sensory abnormalities of these regions”[184].

375. In assessing 5% permanent impairment of the pelvis[185], Dr Watson said that chronic pain and neurological features are a feature of Mr Hallmann’s condition with a “history of pain in the L4/5 and pelvosacral regions with chronic widespread major musculoskeletal pain in the pelvis, groin and sacral regions”[186].

376. Significantly, in my view, Dr Watson on physical examination found pain upon pressure to FM and other pressure points including “tightness in lower back muscles and pelvic area associated with tenderness and pain in the lumbopelvic region”[187]. Dr Watson said[188]:

> “Mr Hallman has a loss of efficient use of the pelvis. He experiences muscle tightness and spasms as well as significant pain in the pelvic, sacral and gluteal region. He receives chiropractic, acupuncture and physiotherapy and there is a concentration upon these areas because of ongoing symptoms. These modalities assist to keep the pain impact managed and prevent deterioration as much as possible there is considerable pain associated with

[181] report of Dr Watson dated 7 December 2012 – Application – pp 85-86
[182] report of Dr Watson dated 12 December 2012 – Application – p 137
[183] supra – p 141
[184] supra – p 265
[185] supra – p 267
[186] supra – pp 320-321
[187] report of Dr Watson dated 27 December 2012 – Application – p 323
[188] supra – p 324

treatment. The issues with the pelvis in terms of loss of efficient use are multiple and can only be described via illustration.

Example 1: When he has significant pain in the sacral region he had difficulty sitting. Sacral pain is a feature of the condition since the onset and recurs at frequent intervals. During such periods, he has difficulty walking and experiences significant discomfort.

Example 2: Pain in the muscles in the gluteal region are common and impact upon his ability to walk and sit with comfort. It is particularly painful during treatment.

Example 3: Mr Hallmann gets periods of groin pain that makes it difficult to walk and to sit.

…

(h) Impairment Rating:
The maximum impairment is 30% for loss of the pelvic region. I estimate his impairment for this region at 15%. The impairment is therefore 5% (14% x 30%).

(i) Comment:
In arriving at this impairment rating, I take consideration of the available evidence of issues that impact this region identified with respect to Section 5.2 above. I note that pain, fatigue and weakness are to be considered an impairment of the part under consideration. The impairment assessment is made on the basis of the most common occurrences of the condition. It is noted that this condition is significantly affected by post-exertional pain. **Apart from the expression of pain, there is a great deal of evidence to demonstrate the existence of inflammation, marked anerobic activity, blood cell deformity, mitochondrial shutdown and muscle damage** (emphasis not in original)."

377. While Dr Watson interchanged between "maximum impairment", "impairment rating" and "loss of efficient use", he referred to the correct item under the Table of Disabilities: "permanent impairment of the pelvis" in his table set out at page 1260 of the Application. The use of the words "loss of efficient use", whilst not the descriptors used under the Table of Disabilities for "loss of power of speech" and "loss of sense of smell", conveys Dr Watson's opinion that Mr Hallmann suffers with a loss or permanent impairment as a result of the injury.

378. The question whether Mr Hallmann suffers with permanent impairment or losses under the Table of Disabilities is solely within the jurisdiction of an Approved Medical Expert.

379. Dr Whiting has been treating Mr Hallmann for his ME/CFS with overlapping FM since December 2011 on referral from Dr Bird. Dr Whiting, whose speciality is Internal Medicine and Infectious Diseases, is a specialist in the diagnosis and treatment of patients suffering with ME/CFS and FM. Dr Whiting has published papers to the medical profession on the subject of ME/CFS and FM, which are set out in his resume attached to his report dated 27 March 2013[189].

380. I find Dr Whiting is a medical expert in the field of ME/CFS and FM.

[189] 2013 resume of Dr Whiting – Application – pp 686-691

381. Mr Hallmann presented to Dr Whiting with fatigue, post-exertional malaise, muscle tightness and pain, joint pain, memory issues and cognitive issues; experiencing photophobia and dry eves with muscle spasm and tightness through the neck, arms legs, back and **pelvis** (emphasis not in original), and other significant symptoms "**such as sensitivity to smells such as perfumes, petrochemicals and similar**" (emphasis not in original) consistent with the diagnosis of ME/CFS with overlapping FM[190]. Dr Whiting said that Mr Hallmann "has the best ever evidenced case of ME/CFS I have seen in my 26-year history of patient care of such illness"[191]. Dr Whiting diagnosed Mr Hallmann to be suffering with ME/CFS with overlapping FM because his symptoms fulfilled the criteria of the 1994 Fukuda Definition[192], 1994 Guidelines and the 2003[193] and 2011 Consensus Documents[194], confirmed by appropriate testing and investigations[195].

382. Dr Whiting reported the following history in respect of the pelvis[196]:

> "He reports general pain in the pelvic region is around 3/10 presently. He reports that the specific areas such as the groin and sacrum can cause significant pain. In the same vein as the back and neck, activity can cause the stiffness and pain to increase within the pelvic region. The general body pain will increase to between 5-6/10. Specific areas in the sacrum will flare from time to time, with particular pain areas of about 6 – 8/10 during a flare up."

383. Dr Whiting has observed the occurrence of stiffness and guarding of the spine impacted by pain and fatigue with stiffness/cramping during periods of increased pain[197].

384. Dr Whiting said the pelvis represents one of the first areas of pain identified in the history of Mr Hallmann's ME/CFS, and that during the early stages of the condition onset, the pain and spasm/tightness hit his back on 29 November 1996, and that the pain was in the groin and progressed to the back and into the sacrum[198].

385. Dr Whiting's history about pain in the groin progressing to the back and into the sacrum is consistent with the history recorded in the patient's card when Mr Hallmann attended upon Mr Mansen on 4 November 1996[199] for chiropractic treatment, and Mr Mansen's report dated 26 February 1999.

386. Dr Whiting said that the initial focus by medical practitioners was on the lumbar spine in the area of the sacrum, along with the arms and legs, but with investigations there were other areas with the progress of his condition including the pelvis, which was treated by attention around the sacrum, including stretching of the psoas and mobilisation of the sacroiliac joints[200].

387. Dr Whiting said that Mr Hallmann reports general pain in the pelvic region as "3/10" and that specific areas such as the groin and sacrum can cause significant pain, and pain in the pelvic region is increased with activity.

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[190] report of Dr Whiting dated 6 March 2013 – Application – p 680
[191] report of Dr Whiting dated 25 July 2013 – Application – p 735
[192] report of Dr Whiting dated 25 May 2014 – Application – pp 779-781
[193] supra – pp 936-937
[194] supra – pp 953-955
[195] supra – pp 939-953
[196] report of Dr Whiting dated 26 May 2014 – Application – pp 1170
[197] supra – Application – p- 1171-1172
[198] supra – p 1252
[199] supra at [65] and [66]
[200] report of Dr Whiting dated 26 May 2014 – Application – p 1252

388. Dr Whiting said he has observed guarding by Mr Hallmann when the pelvis is stiff and painful, and that he changes his posture, placing weight more along his back and away from the sacrum in order to avoid pain in the pelvic area.

389. Dr Whiting opined that there are numerous issues that are a feature of ME/CFS which play a role in the way the muscles and neurological system operate with respect to Mr Hallmann's body, including the pelvis, consistent with his diagnosed condition of ME/CFS[201].

390. In respect of assessment of the pelvis as a condition of ME/CFS, Dr Whiting opined[202]:

> "There is an apparent loss of efficient use of the pelvis. This body part is impacted by pain and fatigue all the time and this reduces his ability to carry his body in a normal posture at times throughout the day, and through periods of enhanced symptoms. During episodes of increased pain and stiffness/cramping the ability to utilise the pelvic region in normal movements is severely reduced. Without ongoing physiotherapy and chiropractic management, this area would be a major problem for Mr. Hallmann. Maintenance accords quality of life and greater mobility and less pain than what would be experienced without it.
>
> I assess the impairment of the pelvis as falling in the mild to moderate range. There are periods where it will fall in the severe range and activity will be prevented. There are periods in the mild range, but activity duration will become less and post-exertional impacts will cause the area to deteriorate.
>
> **Impairment of the pelvis – 30%**" (emphasis in original)

391. Mr Hallmann has been assessed by a number of independent medical experts qualified by the respondent over the years in respect of his claim that he suffers with ME/CFS with persisting FM:

    (a) Dr Sutherland, clinical immunologist and consultant physician;
    (b) Dr King, consultant physician in internal medicine;
    (c) Dr Oakeshott;
    (d) Mr Ross Baines, physiotherapist;
    (e) Dr Pierides, occupational physician (review of file only);
    (f) Dr Stephen Potter, rheumatologist;
    (g) Dr Slezak, and
    (h) Prof Wakefield

392. Prof Wakefield is the only independent medical expert qualified by the respondent who found Mr Hallmann suffers with CFS and FM.

393. Prof Wakefield is a Professor of Medicine and Director of Immunopathology of the South Eastern Sydney Local Health District, and eminently qualified to provide opinions about the conditions of ME/CFS and FM. I accept Prof Wakefield is an expert in this area of medicine.

394. Prof Wakefield has provided a series of reports dated:

    (a) 30 November 2012;
    (b) 30 September 2013;
    (c) 13 July 2014;
    (d) 24 November 2014;
    (e) 7 December 2014, and
    (f) 26 January 2015.

[201] supra – p 1253
[202] supra – p1254

395. Prof Wakefield assessed Mr Hallmann on two occasions: 30 November 2012 and 20 September 2013.

396. Prof Wakefield at the initial assessment diagnosed Mr Hallmann to be suffering from "mild chronic fatigue syndrome, fibromyalgia, possible obstructive sleep apnoea, abnormal stress reaction and intermittent depression"[203].

397. Prof Wakefield at the second assessment confirmed his opinion that Mr Hallmann continues to suffer from "chronic fatigue syndrome with associated fibromyalgia"[204], agreeing with Dr Whiting's opinion that it is unlikely Mr Hallman will recover from these conditions.

398. Prof Wakefield has not provided any opinion whether the pelvis, loss of power of speech and loss of sense of smell is a condition or symptom of MC/CFS with persisting FM; although he commented upon the conditions of dysphasia and aphasia (speech impairments)[205].

399. Mr Hallmann was referred pursuant to s 319 of the 1998 Act to an Approved Medical Specialist for assessment as to whether he suffers with conditions of the pelvis, loss of power of speech and loss of sense of smell as a result of the injury (ME/CFS with persisting FM) or whether as a result of consequential conditions resulting from the injury deemed to have happened on 29 November 1996.

400. The assessment by the Approved Medical Specialist whether the pelvis, loss of power of speech and loss of sense of smell are conditions or symptoms of ME/CFS with persisting FM is a question of causation and not one that is binding upon the Commission in accordance with the principles in *Jaffarie*.

401. The Approved Medical Specialist concluded in her Medical Assessment Certificate issued on 19 July 2018:

> "There is no evidence on either history or examination that he suffers with conditions of the pelvis and loss of power of speech. Again, if he did and, also if he had a loss of sense of smell, it would not be due to his condition of Fibromyalgia/Chronic Fatigue Syndrome, as again I reiterate that this condition from which he does suffer, is considered in mainstream Rheumatology to not cause **any structural damage to the human body** (emphasis not in original). If there is evidence of structural damage or abnormalities found in the body, then the diagnosis must be reviewed, as is another condition, not Fibromayalgia/Chronic Fatigue Syndrome, that are causing these issues."

402. While the Approved Medical Specialist commented upon the report of Dr Whiting dated 24 March 2013, it was in the context of the s 60 claims without considering Dr Whiting's opinion that the complaints of pain in the pelvis are a symptom or condition of ME/CFS with persisting FM.

403. The Approved Medical Specialist seems to have reached her conclusion on her examination and history taken to opine that Mr Hallmann did not suffer "any structural damage" to the pelvis" because "Fibromyalgia/Chronic Fatigue Syndrome" in "mainstream rheumatology" is not considered to cause structural damage.

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[203] report of Prof Wakefield dated 30 November 2012 – Reply – p 391
[204] report of Prof Wakefield dated 30 September 2013 – Reply – p 451
[205] supra – p 459

404. The respondent submitted that what is required to constitute "injury" is a "sudden or identifiable pathological change; not a temporary change in the body's functioning"[206].

405. The respondent accepts the condition of ME/CFS with persisting FM is an injury within the meaning of s 4 of the 1987 Act. In other words, ME/CFS with persisting FM is the "sudden or identifiable pathological change" caused by the injury. The issue is whether the pelvic symptoms, loss of power of speech and loss of sense of smell are conditions of ME/CFS with persisting FM.

406. I prefer the opinions of Drs Watson and Whiting that the pelvic symptoms are a condition of ME/CFS with persisting FM to the opinion of the AMS who seems to have based her opinion upon whether there is "structural damage" without considering if pelvic pain and complaints of restriction of movement of the pelvis are a condition of ME/CFS with persisting FM.

407. Prof Whiting offered no opinion as to whether pelvic pain and restriction of movement of the pelvis are symptoms or conditions of ME/CFS with persisting FM.

408. The history of complaint about the groin and hip area since the first attendance upon the chiropractor in November 1996 and thereafter to other medical providers, but in particular to Drs Bird, Watson and Whiting, supports the conclusions reached by those doctors that the symptoms of the pelvis are a condition of ME/CFS with persisting FM.

409. I do not accept the respondent's submissions that Drs Bird, Watson and Whiting have not applied any intellectual rigour; have lost their objectivity and impartially, and have become advocates in Mr Hallmann's cause, merely accepting his "constellation of complaints" without any proper investigation. The allegations of the respondent call into question the creditability of the long term treating doctors without any proper foundation other than they have critiqued the reports of the respondent's independent experts, and have been critical of the opinion of Prof Wakefield as to his scientific methodology in diagnosing the conditions of ME/CFS and FM. Prof Wakefield has responded to criticisms made of him by Drs Bird, Watson and Whiting, and in return has critiqued their opinions and comments. Whilst there have been criticisms as to methodology and diagnosis of the ME/CFS with persisting FM, Drs Bird, Watson and Whiting and Prof Wakefield are in agreement that Mr Hallmann suffers with ME/CFS with FM as a result of his injury. It seems to be more of greater minds differing as to opinions than a loss of impartiality and objectivity by the treating doctors.

410. I find that the condition of the pelvis, which manifests itself in pain and restriction of movement in the pelvic region, is a condition of ME/CFS with persisting FM.

Loss of power of speech

411. Drs Watson and Whiting are of the opinion that the loss of power of speech is the direct result of the ME/CFS with persisting FM[207].

412. Dr Whiting said:

> "*(c) Speech/Voice*
>
> Mr. Hallmann has numerous issues with respect to the brain, including reduced blood flow to the various lobes of the brain identified in the history and its objective evaluation. The neurocognitive deficits that have been demonstrated are impacting upon his ability to speak, hence, the slurring, stammering and stuttering.

[206] *Castro v State Transit Authority* [2000] NSWCCR 12 at 137-139; *Kennedy Cleaning Services Pty Ltd v Petkoska* [2000] HCA 45; 2000 CLR 286

[207] report of Dr Watson dated 25 May 2014 – Application – p 1408; report of Dr Whiting 26 May 2014 – Application – p 1148 and pp 1231-1232

As a direct result of the condition Mr. Hallmann suffers a loss of efficient use of the power of speech. It is impacting his audibility, intelligibility and functional effect. As a result, he finds himself open to misunderstanding and ridicule. He is a highly intelligent individual who relied heavily upon his ability to speak to ply his trade. His ability to communicate effectively has been dramatically affected. His voice is an important facet of his current occupation and he finds that it causes him problems on a regular basis and as such he often has to repeat himself or is misunderstood by listeners. At its worst, he cannot speak because he cannot effectively form words. He becomes very slow and monotone in presentation, equivalent to what would be expected of a brain injury. To summarise, ME/CFS causes the following:

- He is repeatedly told by people that he talks too quietly;
- In his head, the sound is quite loud and he thinks he is talking inadequately;
- His voice decreases in volume as his fatigue increases;
- He mumbles, stutters and stammers;
- He slurs and his words jumble together as if he is drunk when he becomes fatigued.

In the history provided and **by my own observation** (emphasis not in original), these symptoms are consistent with what he has reported and what is commonly experienced in Me/DFS (Guise, J., McVittie, C. & M McKinlay, A.A. discourse analytic study of ME/CFS (Chronic Fatigue Syndrome) Suffers' Experiences of interactions With Doctors" J Health Psychol April 2010 15: 426-435).

Speech and voice is (sic) assessed in accordance with Table 11-8 and 11-9 at page 265. Table 11-8 proves the three areas of assessment for voice and speech being Audibility, Intelligibility and Functional. Efficiency.

1. Audibility – The history with respect to speech and voice has been documented in previous reports. There is a strong correlation between the increase in symptoms of fatigue and pain (especially post-exertionally) and the decrease in audibility. I have experienced this myself when observing Mr. Hallmann across a number of days in California. He reports that during everyday speech he is often accused of mumbling and asked to speak up. He reports that in places where is noise, he is asked to speak up because he cannot ascertain an appropriate level to speak at. He has the nickname "Muttly" from at least one person at baseball, because of his poor audibility. With the frequency of problems being moderate and the degree of problem being similar, I would rate this as a class 2 range and I would assess a 25% impairment rating;

2. Intelligibility – Mr. Hallmann's intelligibility varies throughout a day. For the most part, he is able to be understood. He does experience problems in intelligibility at points, and this will deteriorate with fatigue and pain as well as post-exertionally. **I have observed that he slurs and becomes unintelligible. He will stutter, mispronounce words, stop and restart or even avoid a word that he cannot get out and use a new word. At points, he sounds like**

he is impaired by alcohol when he has not actually had a drink (emphasis not in original). He is normally quite articulate and he finds deterioration embarrassing. Intelligibility is essential to his role and it is one reason why he could not do his part roles. I consider him to be a class 2 category of impairment and I consider it to be at the top end of the class because of the frequency and the degree that it impacts his life. The impairment is 34%.

3. Functional Efficiency – When fatigued or suffering post-exertional malaise, and he is suffering neuro-cognitive symptoms, Mr. Hallmann struggles to think about what he is talking about. **I have seen him when he enters this point** (emphasis not in original). He will attempt to focus more on what he is doing and saying. He will stop, pause and stammer in the process. He becomes disjointed, difficult to follow, tangential and loses clarity. The drop can be quite dramatic – like he hits a wall in his wherewithal. I rate the impairment as a class 2 on the table and I rate it at the high end of the class because the impact is quite marked and it occurs frequently. The impairment is therefore 34%.

Impairment of speech impairment – 33%"

413. In respect of the conditions of Dysphasia and Aphasia, Dr Whiting opined that the 2012 SPECT brain scan, 2002 qEEG/EEG and psychological measurement in 1999, 2000, 2006 and 2009 establishes a connection between the brain and the neutrally mediated hypotension (NMH)as well as deficits in cerebral perfusion, which are symptoms of ME/CFS[208].

414. Dr Whiting said dysphasia arises when there is damage to certain defined areas on the left side of the brain which impacts the ability to understand, speak, read and write. Dr Whiting said he has witnessed instances where Mr Hallmann is unable to carry on a conversation because he could not understand the crux of the conversation; and he is not able to carry on the conversation because he cannot think or speak properly or think of the words to say.

415. Dr Whiting said that the psychological testing undertaken by Dr Michael King in 2000 and 2009 demonstrates Mr Hallmann has major issues reflective of a brain injury consistent with the presentation of ME/CFS[209].

416. Dr Whiting said the loss of power of speech due to ME/CFS causes the following[210]:

"1. Speech Loss – Loss of Power of Speech

(a) He is repeatedly told by people that he talks too quietly;
(b) In his head, the sound is quite loud and he thinks he is talking adequately;
(c) His voice decreases in volume as his fatigue increases;
(d) He slurs and his words jumble together like he is drunk when becomes fatigued."

[208] report of Dr Whiting dated 26 May 2014 – Application – p 1163
[209] supra – p 1164
[210] supra – pp 1231-1232

417. Dr Bird also assessed Mr Hallmann's loss of speech, describing it as "loss of efficient use of speech", as 20%. Dr Bird said that he had witnessed the following speech impairments over the previous two years (2008 to 2010) as follows[211]:

> "6. ***Loss of Efficient Use of Speech*** – Regarding Mr. Hallmann's permanent loss of efficient use of speech, Mr. Hallman reports having problems with:
>
> (a) Slurring, mumbling and jumbling of words;
> (b) Deterioration of symptoms tired, fatigued or in pain (especially post exertional);
> (c) Stuttering and stumbling in speech."

418. Dr Watson assessed 24% loss of power of speech stating Mr Hallmann has a number of issues relating to his speech that are the result of ME/CFS. He slurs and sounds drunk when he becomes fatigued; mumbles, and the volume of his voice decreases impacting his communications with people, and that the problems have been present since the onset of his condition[212].

419. The only evidence from the respondent's independent medical experts on the issue of loss of power of speech is that of Prof Wakefield who said: "there is evidence that he does have some cognitive impairment related to his chronic fatigue syndrome but to classify these as dysphasia and aphasia is overstating the case"[213].

420. Prof Wakefield provided no further reasons for his opinion that it was overstating the case by classifying dysphasia and aphasia as related to or a condition of ME/CFS.

421. Dr Whiting gave cogent reasons as to the causation of the cognitive impairment (1998 Tilt Table Test; 2012 SPEC scan; 2002 qEEG/EEG, and the results of the psychological testing in 1999, 2000, 2006 and 2009) resulting from ME/CFS establishing the causal link between the conditions of dysphasia and aphasia with the ME/CFS.

422. Drs Whiting and Watson have had the opportunity to observe Mr Hallmann over many years, unlike Prof Wakefield and the Approved Medical Specialist, of him suffering with dysphasia and aphasia.

423. I prefer the opinions of Drs Whiting and Watson to the opinions of Prof Wakefield and the Approved Medical Specialist because of their expertise in the fields of ME/CFS and FM, and their observations of the dysphasia and aphasia, establishing the causal link on a commonsense evaluation between those conditions and the ME/CFS, supported by the results of the 2012 SPEC scan and psychological testing conducted by Dr Michael King establishing cognitive impairments as a result of ME/CFS.

Loss of sense of smell

424. Mr Hallmann relies upon the histories of the symptomology of nasal and sinus infections and the investigations undertaken as set out in paragraph 203; and the opinions of Drs Bird, Watson and Whiting that the nasal and sinus problems are a condition of ME/CFS resulting in loss of sense of smell.

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[211] report of Dr Bird dated 8 March 2010 – Application – p 36
[212] report of Dr Watson dated 27 December 2012 – Application – pp 265-267
[213] report of Prof Wakefield dated 30 September 2013 – Reply – p 459

425. Dr Bird recorded that Mr Hallmann had been suffering with "nasally based staphylococcus infection" confirmed by tests undertaken by Bioscreen Pty Ltd in 1998; that he had been prescribed antibiotics for the condition[214], and that the positive test of "**RNAse L**" in 2000 revealed exposure to a virus consistent with ME/CFS.

426. Dr Bird recorded that Mr Hallmann reported extreme sensitivity to items such as petrochemicals (petrol and diesel), perfumes, deodorants and the like which leads to a headache or migraine[215]. Dr Bird assessed Mr Hallmann to have a 15% permanent impairment of smell.

427. Dr Watson recorded a history that the onset of sinus symptoms began in 1994[216]. Dr Watson said that the "**RNAseL**" test "remains a test consistent for a subgroup of those with ME/CFS"[217].

428. Dr Whiting recorded the following history of acute sensitivity by Mr Hallmann to[218]:

> "(i) Petrochemicals;
> (ii) Perfumes;
> (iii) house deodorisers;
> (iv) fabric softeners;
> (v) personal deodorants;
> (vi) paints (particularly oil);
> (VII) certain glues (like shoegoo);
> (viii) sprays (eg fly spray);
> (ix) chemicals (eg Roundup);
> (x) solvents;
> (xi) new carpets;
> (xii) new car smells;
> (xiii) eucalyptus cream;
> (xiv) pollens;
> (xv) dust and the like."

429. Mr Hallmann reported to Dr Whiting that he had no history of allergy or sensitivity of smell prior to the onset of ME/CFS.

430. Dr Whiting opined that "allergies/sensitivities of this type (referring to the history set out in paragraph 431) are common in ME/CFS (2003 Consensus Document at p. 23; ME/CFS Primer 2012, p. 18)."[219]

431. Dr Whiting assessed Mr Hallmann to be suffering with 30% permanent impairment of his loss of sense of smell.

432. Prof Wakefield took no history from Mr Hallmann of sensitivity of smell. Prof Wakefield provided no comment or opinion if Mr Hallmann suffers with sensitivity to smell, and whether the sinus and nasal infections are a condition of ME/CFS resulting in the loss of sense of smell.

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[214] report of Dr Bird dated 8 March 2010 – Application – p 20
[215] supra – pp 47-48
[216] report of Dr Watson dated 22 December 2012 – Application – p 115
[217] supra – p 128
[218] report of Dr Whiting dated 26 May 2014 – Application – p 1232
[219] report of Dr Whiting dated 26 May 2014 – Application – p 1233

433. The Approved Medical Specialist did not provide reasons for her conclusion that a loss of sense of smell is not a condition due to ME/CFS with persisting FM other than to comment that it was not considered “in mainstream Rheumatology to not cause any structural damage to the human body”.

434. I accept Mr Hallmann’s evidence that he had no sensitivity of smell prior to the onset of his ME/CFS.

435. I accept Dr Whiting’s opinion that the allergies and sensitivities to smell are common in persons suffering with ME/CFS.

436. I am satisfied on balance that the various tests undertaken since 1996 to investigate the sinus and nasal infection problems establishes the causal link on a commonsense evaluation between the loss of sense of smell and the ME/CFS.

437. I find that the loss of sense of smell is a condition of ME/CFS resulting from the injury.

438. The respondent submitted that no tests were conducted by Drs Bird, Watson and Whiting to establish the loss of sense of smell, and therefore Mr Hallmann has not established that he suffers with a loss under the Table of Disabilities.

439. As I have determined the question of causation, the assessment of permanent impairment of loss of sense of smell under the Table of Disabilities is solely within the jurisdiction of an Approved Medical Specialist.

ORDERS

440. I propose to remit the matter to the Registrar for referral to an Approved Medical Specialist/s to assess the losses claimed under the Table of Disabilities with the injury deemed to have happened on 29 November 1996, and for the Registrar to forward a schedule setting out the documents, subject to agreement by the parties, to the Approved Medical Specialist/s.

Other matters in dispute

441. I propose to determine the disputed s 60 claims in a separate Certificate of Determination without delaying the issuing of my determination in respect of the disputed claims for the permanent impairment of the pelvis, loss of power of speech and loss of sense of smell as a result of injury.