SUPREME COURT OF QUEENSLAND

CITATION:	***Emerson v Coles Myer Ltd & Anor*** **[2004] QSC 161**
PARTIES:	**KATE LOUISE EMERSON** (Applicant) v **COLES MYER LIMITED ACN 004 089 936** (First Respondent) and **Q-COMP** (Second Respondent)
FILE NO:	S130/2004
DIVISION:	Trial Division
DELIVERED ON:	27 May 2004
DELIVERED AT:	Rockhampton
HEARING DATES:	8 April 2004
JUDGE:	Dutney J
ORDERS:	**Declare that the reasons for rejecting in part the applicant's claim which reasons are contained in the letter from the first respondent to the applicant dated 28 October 2002 do not comply with the requirements of r. 81 of the *WorkCover Queensland Regulation 1997* (Qld).**
CATCHWORDS:	WORKERS' COMPENSATION – review against decision to reject claim relating to epileptic seizures – where rejection letter not received in the first instance by the applicant – where copy of the letter forwarded to the applicant at a later date by her solicitor – whether time started to run for review proceedings purposes – whether notice of the decision to reject the claim defective – whether "reasons" given for rejecting claim *WorkCover Queensland Act* 1996 (Qld), ss. 33, 119(1), 135, 161(3), 161(4), 196, 197, 253(1)(a)(ii), 260, 261(1), 261(2), 261(3), 261(4), 262(4), 280, 437, 489(2), 489(4), 491(1), 491(4)(a) *WorkCover Queensland Regulation* 1997 (Qld), r. 81

Q-Comp and Diane Baulch (No C97 of 2003, Hall P, 27 February 2004), doubted

COUNSEL: Mr GF Crow for the applicant
Mr PG Bickford for the first respondent
Mr PB Rashleigh for the second respondent

SOLICITORS: Chris Trevor and Associates for the applicant
Minter Ellison for the first respondent
Q-Comp for the second respondent

[1] This application sought relief in the form of leave to appeal against a decision rejecting a claim for compensation or alternatively a declaration that the operation of the *WorkCover Queensland Act* 1996 (Qld) ("the Act") is postponed where the worker is a minor until the worker attains her majority. At the oral hearing of the application it was conceded by the applicant's counsel that the relief set out in the application was inappropriate. It was said that an amended application would be filed setting out the relief actually sought. Although the issues were identified in the course of argument, no amended application has been filed. I am left in the position that the application before me has been effectively abandoned. The only hint I have been given as to what is actually sought is the statement by Mr Crow at page 37 of the transcript of the hearing. At line 49 Mr Crow stated that what is sought is a declaration that the reasons contained in the letter of 28 October 2002, to which I will shortly refer, do not comply with the statutory requirements. Mr Crow intimated that no consequential relief was required. That seems to me to be improbable. I have thus little idea of what this applicant seeks. Nevertheless, I will do my best to deal with the issues raised.

[2] The facts are not in dispute.

[3] The applicant was injured at work on 19 April 2002. An application for compensation dated 20 May 2002 ("the Claim") was received by Coles Myer Ltd Workers' Compensation Claims Unit ("the insurer") on 22 May 2002.

[4] A letter was sent to the applicant advising her that her claim for medical expenses was accepted on 4 June 2002.

[5] On 25 June 2002 the insurer received a medical certificate for epileptic seizures as a result of the accident on 19 April 2002.

[6] The insurer arranged for the applicant to be examined by Dr Alison Reid, neurologist, on 8 August 2002.

[7] On 28 October 2002 the insurer sent a letter to the applicant at the address provided in the Claim advising that the claim was accepted for post traumatic stress disorder but rejected in relation to the epileptic seizure ("the rejection letter"). In the rejection letter the epileptic seizure is referred to in a quoted passage from Dr Reid's report as a "seizure disorder". The letter purported to contain reasons for the rejection. The letter was not received by the applicant. The relevant parts of the letter were in these terms:

> "We refer to your claim for total incapacity, relating to the above injury and advise that in accordance with the WorkCover Queensland 1996; Coles Myer Ltd, as a licensed Self-insurer has accepted your claim from 19/04/2002 for post traumatic stress disorder.
>
> Please note that liability is accepted only in relation to the injury stated above for benefits in accordance with the WorkCover Queensland Act 1996.
> …
> Coles Myer claims Unit however do not accept liability for any aggravation of the seizure disorder as certified by your GP. This decision is based on the report from Dr A Reid wherein she states 'She has had some funny turns since the incident. They are very unusual funny turns and do not sound particularly eleptogenic in nature, and it is far more probable that they have been anxiety based. At this point in time there is no evidence that Katie's epilepsy has recurred and there is even less evidence to suggest that the workplace incident could have even conceivably reactivated previously dormant epilepsy. The neurological examination of the cranial nerves and limbs was normal. CAT scan of brain (22 July 2002) was normal.'
>
> We noted a report from Dr Sandstrom wherein there is no opinion that any re-occurrence of epilepsy as being work related or that work was deemed a significant contributing factor. (*sic*)"

[8] On the 28 October 2002, the insurer also sent a letter to the applicant's solicitor advising him that the claim for post traumatic stress disorder had been accepted. Correspondence followed with a view to the claim progressing. The correspondence from the solicitor to the insurer ultimately enclosed material relating to the seizure. As a result, on 16 April 2003 the insurer wrote to the solicitor advising that a notice of assessment could be issued only for the accepted components of the claim. The solicitor did not respond until 7 July 2003 when he wrote seeking a copy of the correspondence.

[9] On 15 July 2003 the insurer sent the solicitor a copy of the rejection letter. The solicitor sent the applicant a copy of the insurer's letter of 15 July and the enclosed copy of the rejection letter on 5 August 2003. The solicitor says that he was unaware when he forwarded the correspondence of 15 July 2003 to his client that she had not previously seen the rejection letter. He does not say why he sent her the copy of the correspondence but presumably it was to keep her informed of progress.

[10] The insurer forwarded another copy of the rejection letter to the applicant directly in late October 2003. This time the letter was received.

[11] The applicant lodged an application for review of the rejection of her claim in relation to the alleged epileptic seizure with Q-Comp on 23 December 2003. By letter dated 9 January 2004 Q-Comp declined to accept the review on the grounds that the applicant was out of time to have a decision, communicated to her on 28 October 2002, reviewed.

[12] The short submission for the insurer and Q-Comp is that even though the letter sent to the applicant by the insurer in October 2002 was not received by her, she did in fact receive it from her solicitor in early August 2003. The time for appeal is limited by s. 491(1) of the Act to the period of three months after the applicant receives written notice of the decision and the reasons for the decision. The appeal was not lodged with Q-Comp until more than 4 months after the applicant received the copy of the decision from her solicitor. She was thus out of time.

[13] Mr Crow for the applicant responds to this submission in three ways. First, he submits that the letter dated 28 October 2002 did not contain reasons for the decision. Second, he submits that the copy of the rejection letter forwarded to the applicant by her solicitor in order to seek instructions did not constitute the required notice of the decision. Third, he submits that the Act did not authorise the acceptance of the claim in part and the rejection in part. It must, he submitted, be wholly accepted or wholly rejected.

[14] A review of a decision to reject a claim is governed by Chapter 9 Part 2 of the Act.[1] Sub-section 489(2) requires a decision maker to give to give written reasons for the rejection. By s. 489(4) the reasons must address the matters prescribed under a regulation. The matters which must therefore be addressed are set out in r. 81 of the *WorkCover Queensland Regulation* 1997 (Qld) ("the Regulation"). Five matters are specified as matters which must be stated or disclosed in the written reasons. These are:

- The provision of the Act under which the decision is made;
- The evidence considered for the decision;
- The evidence that was accepted or rejected for the decision and why it was accepted or rejected;
- The conclusions drawn from the evidence;
- The link between the evidence, the conclusions and the relevant provisions of the Act.

[15] I am satisfied that the letter dated 28 October 2002 does not contain reasons in accordance with the r. 81. The relevant passages as set out above make no reference to the provisions of the Act under which the decision was made. The only reference to the evidence considered is the quoted passage from the report of Dr Reid and a reference to the absence of an opinion that epilepsy was work related in the report of Dr Sandstrom. It may be that the decision maker had no regard to anything else, including the claim itself and the statements made in it by the applicant, but that is not stated. The report of Dr

[1] See s 489(1)(b)(ii) of the *WorkCover Queensland Act* 1996 (Qld).

Reid contains a number of factual statements which have obviously influenced her opinion and which are inconsistent with the account of the applicant. Presumably, the applicant's account of the incident is rejected where it is at odds with other "documented facts". The purported reasons do not identify the evidence which was accepted or rejected. Apart from setting out a passage from Dr Reid's report there is no identified conclusion drawn from the evidence. Apart from citing the passage from Dr Reid's report, the decision maker does not herself even conclude in express terms that any epilepsy is not incident related. It is not clear from the reasons whether even the existence of epilepsy is accepted although a reader might infer from the quote from Dr Reid's report that it is not.

[16] The matters set out are sufficient to demonstrate that no serious attempt has been made in the purported reasons to address the matters prescribed by r. 81. The deficiencies in the reasons here are so great that it is unnecessary to consider whether substantial compliance with r. 81 would have been sufficient. Quite apart from r. 81 I do not consider the contents of the rejection letter could be regarded as a proper statement of reasons for the same reason it does not satisfy r. 81. The purpose of a statement of reasons in this context is so that for the purpose of a review, or for considering whether seeking a review is justified, the applicant is informed, at least, as to the bounds of any factual dispute and the nature and scope of any divergence of expert opinion. The applicant is also entitled to know precisely what factors influenced the adverse decision so that she knows whether or not those matters can be addressed.

[17] Since this conclusion exhausts the live applications made either orally or in writing before me it is strictly unnecessary to proceed further. Nonetheless, since the matter has been argued I will address the further arguments and may entertain a further application for relief subject to hearing the parties.

[18] Since by s. 491(1) the time for review is 3 months after receipt, inter alia, of the reasons for the decision, the failure to give reasons as required by the Act prima facie would mean that the time for the review would not run.

[19] Mr Bickford for the insurer submitted that if I were to reach this point it would be necessary to consider the impact of s. 491(4) which deals with the failure to provide reasons. The effect of s. 491(4) is as follows. If no reasons are provided for a decision, reasons must be requested within 28 days and provided within 7 days of the request. The 3 month time limit for review then runs from the date of provision of the reasons.

[20] It was submitted on behalf of the insurer that if no reasons were requested within 28 days after the receipt of the decision the right to require reasons is lost and the time for review is 3 months from the date of receipt of the decision. It was further submitted that it could not be the case that a person who requested reasons would be worse off than if they had not requested reasons as mandated by s 491(4)(a). I am not sure that there is in fact any such unfairness. In my view the consequence of failing to request reasons within 28 days is that thereafter there is no obligation on the part of the decision maker to supply them. The word "must" in the paragraph means "must if the applicant wants reasons". If no reasons are requested the applicant must conduct any review of a decision rejecting a claim without the advantage of a clear statement of the basis on which the application was previously rejected. Since the decision to reject the claim is effective even without reasons being supplied there is no obvious advantage to the applicant to delay the application at all. Unless the decision to reject a claim is set aside on review the applicant simply does not receive any compensation for the rejected injury. For the purposes of a common law claim the limitation period is continuing to run against an applicant who, as a result of the decision to reject the claim, does not fall within the class of persons entitled to commence proceedings. Proceedings can only be commenced if an application for compensation has been accepted or a notice of assessment has issued and then, notwithstanding s. 261, the claim can only progress to an action in relation to assessed injuries[2].

[2] See s. 266 *Work Cover Queensland Act* 1996 (Qld).

[21] In the result, it does not seem to me that any violence is done, either to the language of s. 491 or to the spirit of the section, if subsections (1) and (4) are treated as discrete provisions, in each of which, a trigger for time commencing to run is the provision of reasons. If reasons are not provided and the insurer wishes to start the time for review running, it can do so simply by providing the applicant with reasons addressing the matters specified under the regulation. The interpretation contended for by Mr Bickford would seem to me to be appropriate only if the words "and the reasons for the decision or failure" were omitted from s. 491(1). In that event there would remain the obligation to give reasons imposed by s. 489(2) and if such reasons were not given the applicant could obtain an extension of time for a review by requesting reasons under s. 491(4). Construing the present legislation in that way gives no operative effect to the relevant words in s. 491(1).

[22] It thus follows that the time for seeking a review of the decision rejecting the claim for epileptic seizure has not yet commenced to run.

[23] The second issue on which the parties made submissions was whether, for the purposes of Chapter 9 Part 2 of the Act the receipt by the applicant of the copy of the rejection letter forwarded to her by her own solicitor constituted receipt of written notice of the decision. If it did not then the first notice received by the applicant would have been the letter from the insurer in late October 2003. If the latter was the case then on any view the application for review was within the three months time period from receipt of the notice.

[24] Sub-section 161(3) of the Act requires the insurer[3] to give notice of a decision. If the decision is to reject an application, s. 161 (4) requires that the notice be accompanied by reasons for the decision and the information prescribed under a regulation. If s. 161 is read as a whole there can be no doubt that the notice and reasons referred to in s. 491(1) are the same notice and reasons to which s. 161 refers. The scheme of the Act is that the notice of rejection must be provided to the applicant under s. 161(3). Ignoring the issue of reasons, if the

[3] *WorkCover Queensland Act* 1996 (Qld) s. 161 refers specifically to WorkCover. Sub-section 119(1), however, imposes a like obligation on a self insurer.

applicant wishes to contest that rejection she must, under s. 491(1), apply for a review within three months after receiving that notice. The obligation to furnish that notice and those reasons is expressly cast on the insurer. It thus seems to me that an insurer does not discharge that obligation if, by no deliberate act or intention on the part of the insurer, the applicant receives from a third party and for a different purpose, a copy of a document which coincidentally informs her of the decision made by the insurer. In my opinion the notice can only satisfy the obligation imposed by s. 161(3) if it comes directly from the insurer; or from some person to whom the insurer has provided the notice for the purpose of passing the same on to the applicant by way of notification of the decision; or if it is given to a person authorised to receive such a notice on behalf of the applicant. An example might be where a solicitor has accepted service of a notice on behalf of a client. That is not this case. I do not consider that the insurer has discharged an express obligation merely because, by accident, and without any conscious intention on the part of the insurer, the applicant has gained possession of a copy of the document containing the notice.

[25] Leaving aside arguments about the content of the notice, the applicant did not receive the s. 161(3) notice in an operative sense until the insurer sent it to her in late October 2003. Her application for review was therefore within the prescribed time.

[26] Since I am considering the operation of the time limit in s 491(1) of the Act, I should comment on one further submission made on behalf the applicant. I was referred to a decision of the Industrial Court in *Q-Comp and Diane Baulch* (No C97 of 2003, Hall P, 27 February 2004). The decision appears to conclude that the time limit for an application to review in s 491(1) is merely directory and the failure to comply strictly will not invalidate the application for review if there has been substantial compliance. Since the only right to review a rejection decision on the merits which an applicant has is the right granted to the applicant by the statute itself, it follows that if that right is limited by the imposition of a time constraint, the failure of an applicant to bring herself within that time constraint must be fatal. That is because she

could not bring herself within the scope of the statutory right. It is not necessary to consider the issue further in this matter because of my conclusions regarding other issues raised. Nonetheless, I have great difficulty in accepting that a statutory provision authorising a review of a decision within a specific limited time, without a power to extend time being conferred, authorises an application outside the prescribed time.

[27] In this case, I am satisfied that the application to review the decision of the first respondent to reject a claim for compensation for epileptic seizure was made within the time prescribed in s. 491(1) of the Act.

[28] The final issue canvassed concerned whether or not the Act permits an application for compensation to be accepted in part and rejected in part. The submission on behalf of the applicant was that once any injury claimed in the application is accepted the application as a whole is accepted.

[29] It was submitted that this is the position because the power to accept or reject an application for compensation arises in relation to the application itself and not in relation to the injuries claimed within it. It was further submitted that an examination of ss. 33, 253(1)(a)(ii), 260, 261(1), 261(2) and 261(3)(a) and (b) of the Act leads to this conclusion.

[30] Section 33 defines an "event" as anything that results in an injury. It also recognises the possibility of multiple injuries from an event. Sub-paragraph 253(1)(a)(ii) gives a person who has not received a notice of assessment for an injury, but who has received a notice of assessment for a different injury arising from the same event, the right to seek damages for the injury for which there is no notice of assessment. Section 260 makes s. 261 applicable to a person identified in s. 253(1)(a)(ii). Sub-section 261(1) prevents WorkCover requiring that the unassessed injury be assessed. Sub-section 261(2) prevents WorkCover deciding that a notice of claim under s 280 is non-compliant because the claimant does not have a notice of assessment for an injury. Sub-section 261(3) prevents the worker claiming damages until WorkCover determines that the claimant was "a worker" when the injury was sustained

and has sustained an "injury". By s. 261(4) the determination in s. 261(3) must be made within 3 months after the receipt of a complying notice of claim under s. 280. Section 437 empowers WorkCover to refer medical questions involved in the determination of whether a worker has sustained an injury and the nature of that injury to a tribunal. Sections 196 and 197, which relate to a workers right to have an injury assessed, were also submitted to be relevant.

[31] It was submitted that the conclusion this analysis of the statutory provisions leads to is that the initial step is to determine if there is an injury and if so s 161 required WorkCover to accept the application. The question of whether all claimed injuries are to be accepted is left to a later stage of the process.

[32] In my view this argument is wrong. The principal provisions to which I have been referred relate to a claim for common law damages. This application is one for compensation under the statutory scheme. It seems to me to be axiomatic that a worker is only entitled to statutory compensation for an injury recognised by the legislation as one entitling her to compensation. An application may contain claims in relation to a number of injuries. One or more of these claimed injuries may be of more lasting duration than others. It would be an odd result, if, by claiming for all the alleged injuries in a single application, the insurer is precluded from considering which injuries are injuries to which the Act applies. The result might be that an applicant is entitled to receive compensation for an ongoing disability arising from an injury to which the Act does not apply merely by including in the application for compensation a transitory injury for which compensation is available.

[33] The real flaw in the applicant's argument, however, is that the provisions in Chapter 5 Part 2 of the Act on which the applicant relies relate only to WorkCover (or a self insurer) being unable to reject a notice of claim merely because one of the injuries has not been assessed. Section 262(4) makes it clear that the assessment relates only to the degree of permanent incapacity and not to whether or not the injury is an injury to which the Act applies. The right to seek damages for any injury is conditional on the insurer accepting that the claimant was a "worker" and sustained an "injury". The same

decision must be made in determining the entitlement of a claimant to compensation under s. 135 of the Act. Compensation is available only for an "injury" sustained by a "worker". Section 161 is merely a mechanical provision for dealing with whether those prerequisites are met. Thus it follows that the insurer is required to deal with each claimed injury whether they are contained in a single or multiple applications for compensation.

[34] The result of this analysis is as follows:

(a) I am satisfied that no "reasons" were provided for the decision rejecting the epileptic seizure claim.

(b) In the result, time does not run for seeking a review until such reasons are provided.

(c) I am not satisfied that the applicant received the required written notice of the decision until late October 2003.

(d) I am not persuaded that there is any reason why the insurer is precluded from assessing whether any individual injury claimed in an application is an injury to which the Act applies.

(e) In my view the three month time limit in s 491(1) of the Act is mandatory.

[35] For the reason I have given I will hear argument on whether I should make any other order apart from the declaration that the reasons contained in the rejection letter do not comply with the requirements of the Act.

[36] I will also hear argument as to costs in the light of what, if any, other orders I make.