THE COUNTY COURT OF VICTORIA
AT MELBOURNE
CIVIL DIVISION
DAMAGES AND COMPENSATION
SERIOUS INJURY DIVISION

Revised
Not Restricted
Suitable for Publication

Case No. CI-11-02173

LYNETTE PATTISON — Plaintiff

v

HERALD & WEEKLY TIMES LIMITED — Defendant

JUDGE:	HIS HONOUR JUDGE MISSO
WHERE HELD:	Melbourne
DATE OF HEARING:	30 and 31 July and 1 August and 6 December 2012
DATE OF JUDGMENT:	19 December 2012
CASE MAY BE CITED AS:	Pattinson v Herald & Weekly Times Limited
MEDIUM NEUTRAL CITATION:	[2012] VCC 2014

REASONS FOR JUDGMENT

SUBJECT: ACCIDENT COMPENSATION
CATCHWORDS: Application for leave to bring a common law proceeding – serious injury – leave application not to be commenced unless the application for determination was made before the expiration of 3 years after the date incapacity "became known" – onus of proof on the plaintiff – sufficient to prove absence of subjective knowledge of facts which, viewed objectively, would constitute serious injury – clinical diagnosis made after 3 years expired – onus not discharged
LEGISLATION: *Accident Compensation Act* 1985, s135AC
CASES CITED: *Papercorp Pty Ltd v Nicolaou* [2006] VSCA 143; *AEP Industries Australia Pty Ltd V Mahmoud* (2007) 17 VR 144; *Morris & Joan Rawlings Builders and Contractors v Rawlings* [2010] VSCA 306; *Hurwood v State of Victoria* [2005] VSCA 176; *Edwards v McSaveney* [2005] VSCA 252; *ACN 005 926 Pty Ltd v Snibson* [2012] VSCA 31
JUDGMENT: the plaintiff's Originating Motion is dismissed.

APPEARANCES:	Counsel	Solicitors
For the Plaintiff	Mr A Ingram	Holding Redlich
For the Defendant	Mr I McDonald	Wisewould Mahoney

HIS HONOUR:

Introduction

1 By an Originating Motion filed 17 May 2011, the plaintiff seeks leave to bring a proceeding to recover damages for injuries she suffered in the course of and within the scope of her employment with the defendant.

2 The leave sought by the plaintiff is based upon a period of employment of the plaintiff's employment spanning 1973 to 1990. Her work colleagues smoked cigarettes which created significant quantities of cigarette smoke in the atmosphere of the building in which the plaintiff worked. She inhaled the cigarette smoke, which she says resulted in her suffering an injury generically described as chronic obstructive airways disease. The claimed period of exposure is from 31 August 1985 to 1990, except for a period of twelve months in 1986 to 1987 when the plaintiff was absent from her place of employment.

3 The proceeding is brought pursuant to s135A(19) of the *Accident Compensation Act* 1985 ("the *Act*") requiring the plaintiff to demonstrate that she has suffered a "*serious long term impairment or loss of a body function*". Additionally, the plaintiff must satisfy me that she is not barred from bringing the proceeding by reason of s135AC of the *Act.*

4 Mr A Ingram of Counsel appeared for the plaintiff, and Mr I McDonald of Counsel appeared for the defendant.

5 The plaintiff and the defendant filed voluminous Court Books. A significant proportion of material in both Court Books became irrelevant. For the purpose of convenience only, I permitted the plaintiff to tender her Court Books, but with a strongly worded rider that I would only read the documents I was taken to by Counsel.

6 The evidence adduced during the proceeding is as follows:

- The plaintiff gave evidence and was cross-examined.
- Dr Fisher, now retired, and a former general practitioner, gave evidence and was cross-examined.
- The plaintiff tendered her Court Books ("PCB") pages 1-704: Exhibit A
- The affidavit of Mr Schaefer, solicitor, together with exhibit "MDA 1": Exhibit B
- The report of Dr Trembath, respiratory physician, dated 15 October 2012: Exhibit C
- The defendant tendered its Court Book ("DCB") pages 1-5: Exhibit 1
- An extract of the clinical notes of the Hazelwood Community Health Centre: Exhibit 2
- Reports of Dr Sasse from 5 March 2009 to 13 June 2012: Exhibit 3
- Handwritten report of Dr Edwards, general practitioner, dated 1 August 2012 and an extract of his clinical notes: Exhibit 4.

The Principles of Law

7 Before turning to the facts, it is necessary to understand the relationship between s135A(19) and s135AC in order to determine what onus the plaintiff bears in order to obtain the leave she seeks.

8 Section 135A(19) places the onus on the plaintiff to prove that she has suffered a serious long-term impairment or loss of a body function.

9 Section 135AC imposes an added onus on the plaintiff in this proceeding. It is in the following terms:

> "Despite anything to the contrary in the **Limitation of Actions Act 1958**, proceedings in accordance with section 135 or 135A must not be commenced—

(a) subject to the **Limitation of Actions Act 1958**, unless paragraph (b) applies, unless an application for a determination from the worker under section 135A(2B) has been made to the Authority or a self-insurer before 1 September 2000; or

(c) if the cause action arose before 12 November 1997 and the incapacity arising from the injury was not known until after 12 November 1997, unless an application for a determination from the worker under section 135A(2B) has been made to the Authority or a self-insurer before the expiration of 3 years after the date the incapacity became known."

10 Mr Ingram and Mr McDonald informed me that the application referred to in s135AC(b) was made to the Authority on 24 December 2010. Therefore, the three-year period, also referred to in this section, commences on 24 December 2007.

11 Section 135AC(b) has been the subject of comment in a number of decisions of the Court of Appeal. I propose to refer to only three Court of Appeal decisions which I think demonstrate the principles of law which must be followed and the process of reasoning which must be applied by the trial judge. The first of those decisions is *Papercorp Pty Ltd v Nicolaou*,[1] in which the Court of Appeal dealt with the type of consequences meant by the word "incapacity" found in s135AC(b):

> "It appears to me, in the event, that the words 'the incapacity arising from the injury' in s 135AC(b) should be taken to mean any consequence, known to the worker, deriving from compensable injury, whether constituted by pain or suffering, or pecuniary disadvantage, or both, which would found a successful serious injury application. So to read the critical words is to recognize that 'the [serious injury] incapacity arising from the injury' may be sufficiently constituted for the purposes of the subsection by a single consequence. Indeed, so far as the present issue of construction is concerned, the conception of consequences of different kinds — the presence of one or more of which may enable an injury to be characterized as serious injury — may be regarded as something of a distraction. It is the language of Humphries and not of the statute." [2]

12 The next relevantly is *AEP Industries Australia Pty Ltd V Mahmoud*[3] in which the Court of Appeal said that the following is the approach which must be applied in a proceeding in which the plaintiff faces the bar imposed by

1 [2006] VSCA 143
2 paragraph 33.
3 (2007) 17 VR 144

s135AC:

> "It was accepted on the appeal that s 134AC(b) involves a two-step process. First, the trial judge must identify what the injured worker in fact knew in relation to his injury at the relevant time. Second, the judge must determine whether in the judge's opinion — and this is a matter of fact and degree and value judgment for the judge — those known facts constitute knowledge of serious injury incapacity as explained in *Humphries v Poljak*. … ."[4]

13 Lastly, the most recent exploration of the subject by the Court of Appeal is *Morris & Joan Rawlings Builders and Contractors v Rawlings*[5] in which a five-bench Court of Appeal succinctly stated the relevant principle of law as follows:

> "The respondent's application was properly to be regarded as barred by s 135AC if 'the incapacity arising from the injury' was known on or before 12 November 1997 — in which case s 135AC(b) would have had no application, leaving the application barred because the respondent did not make an application under s 135A(2B) before 1 September 2000. Alternatively, the application was properly to be regarded as barred by the operation of s 135AC(b) if the respondent had knowledge of the incapacity, arising from his pre-12 November 1997 injury, more than three years before 21 December 2007. The incapacity being spoken about is, of course, serious injury incapacity. It is sufficient to bar the claim if the respondent knew of facts that, viewed objectively, constituted the serious injury incapacity. The fact that an applicant/worker (in this case the respondent) does not subjectively appreciate that the injury is serious until after the relevant date is not necessarily determinative."[6]

14 In connection with the party who bears the onus, the Court of Appeal in *Rawlings* said:

> "For these reasons, we are of the view that it is for the worker to establish that his or her application was made under s 135A(2B) within the three year period after the date the incapacity became known. We are fortified in this conclusion by the existence of decisions subsequent to *Paget* which have (without argument) assumed the correctness of this proposition."http://www.lexisnexis.com/au/legal/ - 44#44[7]

The Plaintiff's Evidence

15 The plaintiff was born in India in 1944. The plaintiff migrated to Australia in

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4 at 146

5 [2010] VSCA 306

6 Paragraph 36. Footnotes deleted

7 Paragraph 31. The Court of Appeal referred to the following decisions in support of that proposition - *Hurwood v State of Victoria* [2005] VSCA 176, [11(f)]; *Edwards v McSaveney* [2005 VSCA 252, [14] and *Papercorp Pty Ltd v Nicolaou* [2006] VSCA 143, [19], and also see *ACN 005 926 Pty Ltd v Snibson* [2012] VSCA 31

1965. She is now sixty-seven years of age. She is a widow. She has three adult children who are independent of her.

16 The plaintiff worked with the defendant for seventeen years from 1973 to 1990. She ceased work in 1990 due to a back condition which she developed in 1990. The work she performed with the defendant was as a typist. She worked in a large open area occupied by about sixty employees of the defendant. The majority of them smoked cigarettes. She described her work area as being full of smoke. By the end of the day, smoke was hanging in the air. She has never been a smoker.

17 During the time she was employed by the defendant, she developed a cough. She brought up sputum, which was often discoloured, and sometimes bloodstained.

18 Dr Fisher became the plaintiff's principal treating medical practitioner. Dr Fisher was one of a number of medical practitioners in the same practice group who practised from clinics at Churchill, Traralgon and Morwell. I was taken to his medical records by both Mr Ingram and Mr McDonald.[8] The first occasion that the plaintiff attended at the Morwell clinic was on 6 June 2000 when she saw Dr Edwards, general practitioner. The entries referred to by Mr Ingram and Mr McDonald are many, and some very extensive. I will summarise the relevant entries,[9] the symptoms complained of by the plaintiff and the treatment she was provided:

- 6 June 2000 – difficulty breathing and suffering palpitations
- 9 November 2000 – cough, sputum
- 23 December 2000 – ongoing dry, irritating and persistent cough over three months – dark brown phlegm – Ventolin and sinus nasal spray

8 Exhibit 2

9 including some relevant entries from a record of the Latrobe Regional Hospital

- 10 February 2001 – productive cough, brownish yellow phlegm for two weeks – Rulide tablet

- 17 April 2001; 2 May 2001; 7 May 2001; 28 August 2001 and 4 September 2001 – Ventolin

- 17 June 2002 – coughing up purulent sputum 4-6 weeks – associated wheezing – Ventolin and Becotide inhaler over previous four years – diagnosis of acute sinusitis – referred for diagnostic imaging of sinuses and chest

- 26 August 2002 – coughing up purulent sputum 3-4 weeks with some wheezing – diagnosis of acute sinusitis

- 4 August 2003 – sore throat one and a half weeks – coughing up purulent sputum for two weeks with wheezing – diagnosis of acute sinusitis

- 25 November 2004 – attended Latrobe Regional Hospital – pneumonia[10]

- 17 December 2004 – attended Latrobe Regional Hospital – productive cough – pneumonia[11]

- 22 January 2006 – attended Latrobe Regional Hospital – cough for one month producing white/yellow coloured sputum – Ventolin[12]

- 24 January 2006 – cough for 10 months with production of purulent sputum – chronic asthma for at least two years

- 25 January 2006 – lung function test conducted by Regional Respiratory Service reported by Dr Connor, physician, as follows:

> "Normal spirometric values, with no further significant acute bronchodilator response demonstrated. (although Pt. 'felt better'.)

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10 PCB 553
11 PCB 61
12 PCB 45-46

Carbon Monoxide diffusing capacity is mildly impaired … ."[13]

- 15 February 2006 – coughing up purulent sputum – diagnosis suggesting emphysema
- 29 May 2006 – Ventolin and Flixotide inhalers
- 2 June 2007 – coughing up purulent sputum for two weeks with wheezing
- 13 September 2007 – coughing up purulent sputum for three weeks with wheezing
- 30 October 2007 – recurrent purulent rhinorrhoea with recurrent cough for four weeks – Prednisolone
- 12 November 2007 – coughing with production of purulent sputum for three days – asthma attacks – Ventolin, Serotide, Flixotide, Zinnat and Prednisolone
- 28 November 2007 – recurrent coughing and wheezing over four weeks – Ventolin, Zinnat and Prednisolone
- 5 December 2007 – recording of two attendances at the Latrobe Regional Hospital for flare-ups of asthma – Prednisolone and Rhinocort
- 7 January 2008 – lung function test conducted by Regional Respiratory Service reported by Dr Connor, physician, as follows:

  > "Normal spirometric values, with no further significant acute bronchodilator response demonstrated.
  >
  > Carbon Monoxide diffusing capacity remains sig. impaired, ? Reason."[14]

- 16 January 2008 – recurrent coughing for three months with wheezing at night, and producing purulent sputum about twice a week – diagnosis suggesting emphysema – Seretide, Prednisolone and Ventolin

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13 PCB 17

14 PCB 81

- 24 January 2008 – prescription for Spiriva.

19 I preferred to set out a summary of what is contained in the clinical notes because of the unreliable nature of the evidence of Dr Fisher. I was informed that Dr Fisher had a benign tumour removed from his brain which has left him with side-effects which include vertigo, nausea, dizziness, and he is now suffering from depression. Dr Fisher retired from active practice in March 2011.[15]

20 Dr Fisher gave evidence on 30 July 2012. It was very clear to me that he was struggling to assemble a workable independent recollection of his treatment of the plaintiff, and to respond to examination-in-chief and cross-examination going to his diagnosis and treatment of the plaintiff's lung condition.

21 At the end of Dr Fisher's evidence I commented to Counsel that I was really not quite sure what to make of Dr Fisher's evidence. He seemed to almost agree with any proposition that was put to him by both Mr Ingram and Mr McDonald. I will return to the question of what I can accept of Dr Fisher's evidence later in these reasons.

22 The plaintiff swore an affidavit on 23 December 2010. In that affidavit she referred to the onset of symptoms of a lung condition and the course of it as follows:

> "10 During the course of my employment with the Defendant I began to suffer some problems such as coughing, and later coughing up sputum which sometimes had bloodstains therein. I was not sure as to the cause of these problems and continued on with my work as indicated until 1990.
>
> 11 As I have also indicated after I ceased work my lung function continued to remain a problem for me and to deteriorate. I was referred for lung function tests by my local practitioner Dr Fisher and I believe that those tests were performed on 25 January 2006 and 7 January 2008."[16]

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15 That is referred to in a report of Dr Edwards dated 27 August 2012: Exhibit B. That report also corroborates some of the evidence of Dr Fisher relevant to his treatment of the plaintiff, and what is recorded in his clinical notes

16 PCB 11

23 Mr McDonald cross-examined the plaintiff at some length regarding the onset of symptoms of the lung condition. He referred the plaintiff to the history recorded by Dr Trembath in his report dated 3 March 2011:

> "She states that her symptoms initially began in about 1983 by her estimate, though she is vague about the exact date of onset of symptoms. At around this date, she started to consult her local doctor because of symptoms of 'bronchitis'. She described these as episodes where she felt tight in the chest and there was a lot of sputum.
>
> At that time her local doctor diagnosed these symptoms as bronchitis, though asthma could be in an alternative explanation. She was treated with antibiotics and cough mixtures.
>
> She states that the onset of these symptoms would have been about 1983 but the nature of the symptoms changed somewhat in about 1985 to 1986. At that stage, she states that her symptoms were more frequent and severe, and while occurring in the workplace in particular, the symptoms might also develop while she was at home or in her local church. She stated that she often experienced attacks just after finishing work. While she was on holidays, she stated that the episodes were not as severe. However she stated that she 'still had it'."[17]

24 Mr McDonald then cross-examined the plaintiff at some length regarding the approximate time when her symptoms developed and the course those symptoms took, based upon the history recorded by Dr Trembath:

> "Q. Did you also see another doctor at the request of the defendant in these proceedings at Dr Peter Trembath in Erin Street, Richmond in March 2011?---
>
> A. I might have, yes.
>
> Q. His report is at p.1 of the defendant's court book, Your Honour. Did you tell Dr Trembath that your symptoms developed in about 1983? At the bottom of the page, Your Honour, the first page?--
>
> A. I might have, I can't remember.
>
> Q. Is that your recollection that is about when they developed, about 1983?---
>
> A. I might have said that, I am not sure.
>
> Q. Did you also tell him the nature of your symptoms changed somewhat in about '85 to '86 and at that stage your symptoms were more frequent and severe?---
>
> A. I could have told him that, yes.
>
> Q. Is that the truth of the matter as far as you are concerned?---

[17] DCB 1-2

A. That is the truth; it got worse.

Q. It occurred at the workplace in particular?---

A. Yes.

Q. It might also have developed while you were at home or in the local church?---

A. Yes, I used to get attacks then.

Q. Did you also say to him that you often experienced attacks just after finishing work?---

A. Sometimes, yes.

Q. That was your experience?---

A. A few times, yes.

Q. Were your symptoms worse at the end of each working day?---

A. Sorry?

Q. Were your symptoms worse at the end of each working?---

A. Some days, yes.

Q. Was it also the situation that when you were on holidays your episodes were not as severe?---

A. That's right.

Q. Was it approximately 1985 when you were first prescribed a puffer to relief your symptoms for asthma?---

A. Yes.

Q. Was it the situation that you felt adversely affected by the workplace in relation to your health?---

A. Yes.

Q. That is why you left in 1990?---

A. Yes.

Q. By that you are referring to your lung problem, are you?---

A. Yes.

Q. Did you tell Dr Trembath that you were finding it hard to cope with the sickness and being on time for work at that you were tired all time?---

A. Yes.

Q. Did you tell him that you were experiencing persistent night time cough and sleep was affected?---

A. Yes.

Q. Did you also tell him this, that after you gave up your job at the Herald Sun newspaper you continued to have significant episodes of shortness of breath and was finding it difficult to cope?---

A. Yeah. Yeah.

Q. That was also true?---

A. Yeah.

Q. And at the present time you remain significantly affected by those symptoms?---

A. Yes.

Q. Have those symptoms basically been the same over the years since you left the employment?---

A. Yes. Sometimes they get a bit worse.

Q. Sometimes they are better, sometimes they're worse?---

A. Yes.

Q. But the nature of the symptoms has basically been the same?---

A. Yes."[18]

25 Mr McDonald then cross-examined the plaintiff from Dr Fisher's clinical notes regarding her exposure to cigarette smoke, and the advice that she was given by Dr Fisher of the connection between the development of her lung condition and the inhalation of cigarette smoke:

"Q. It seems like the next consultation specifically in relation to your lung condition was on 17 June 2002. That is at p.14,Your Honour, and the doctor's notes state that you had been coughing up purulent sputum for four to six weeks associated with wheezing?--

A. Yeah.

Q. Did you tell the doctor on that occasion that you had been exposed to cigarettes for 31 years in the advertising section in Melbourne?---

A. Yeah, he asked me, 'Why you coughing all the time, do you smoke?' I said, 'No but I have been in the company of smokers', I said.

Q. Did he indicate to you whether there was any relationship between that exposure and these problems that you were having in relation to you lung?---

[18] transcript 27-29

A. He did. He did.

Q. That was in June 2002?---

A. Yeah.

Q. Did you tell him that you had used a Ventolin inhaler and a Biaxsig inhaler for four years until you left to look after your mother six years ago?---

A. Yeah."[19]

26 Mr McDonald then cross-examined the plaintiff regarding an apparent hiatus in her treatment between 2003 and 2006:

"Q. It then appears that there is a gap for a couple of years until early 2006. Can you remember whether between 2003 and 2006 there was any improvement in your condition or it was staying the same but you were not seeing the doctor or the medications were taking care of it or what was the situation?---

A. Dr Fisher was transferred to Bairnsdale so I probably saw the local doctor.

Q. That would be a local doctor located in?---

A. In Morwell.

Q. Morwell?---

A. Yes.

Q. Can you recall who that might have been?---

A. She was a Vietnamese doctor. What was her name? I can't remember her name but the centre is still there in Morwell."[20]

27 In relation to the treatment provided by that medical practitioner, the plaintiff said:

"Q. Was Dr Pham treating you for similar sorts of symptoms that Dr Fisher had been treating you for between 2003 and 2006?---

A. Yes, yes.

Q. So when Dr Fisher returned from wherever he had been then you resumed your attendances with Dr Fisher?---

A. Yes.

Q. So we then have an attendance with Dr Fisher on 24 January 2006. It is court book p.23, Your Honour. He has obtained

19 Transcript 31
20 Transcript 32

according to his notes he has obtained this history: 'Recurrent cough for 10 months associated with purulent sputum.' Was that the situation that you had had a recurrent cough for 10 months?---

A. Yes.

Q. That was associated with the sputum?---

A. Yes.

Q. A previous medical history of Pertussis at the age of four to five years, Pertussis?---

A. I don't know what - - -

Q. It is just something the doctor has noted, Pertussis, is that a medical condition that you have suffered from at some point in your life?---

A. I can't recall that.

Q. 'Chronic asthma for two years at least,' is that what you told the doctor that you had been suffering from chronic asthma for two years at least?---

A. I might have told her that. I can't remember."[21]

28 Mr McDonald cross-examined the plaintiff regarding advice given to her by Dr Fisher at a consultation on 15 February 2006:

"Q. He has taken a history that you were exposed to cigarette smoke for 37 years?---

A. 32 years it should have been.

Q. Then his note reads: "The lung function test suggests emphysema but anaemia must be excluded." Was that something that he told you about? Did he tell you that the lung function test suggested emphysema?---

A. Dr Fisher you said?

Q. Yes?---

A. Yes."[22]

29 And later on the subject of advice given at around that time:

"Q. Did Dr Fisher tell you at that stage that he thought your lung problems were related to the cigarette smoke that you had been exposed to at the Herald and Weekly Times?---

[21] Transcript 33-34
[22] Transcript 34

A. Yes, he did."[23]

30 Mr McDonald then cross-examined the plaintiff regarding the course her symptoms took, and whether they were worsening from 2007:

"Q. Is it the situation that commencing about early 2006 and going into 2007 your condition was getting worse, was it slowly getting worse?---

A. Yes.

Q. Becoming more persistent?---

A. More persistent.

Q. Is it the situation that since 2007 there has not been a significant change in the symptoms that you have suffered as experienced by you?---

A. No I find them getting progressively a little worse each time.

Q. Is that just as time goes on?---

A. Yes.

Q. You are getting slowly worse, that is your experience of it?---

A. Yeah.

Q. The symptoms themselves haven't changed particularly?---

A. They have gone more severe like.

Q. The symptoms would include the coughing?---

A. Yeah.

Q. The shortness of breath?---

A. Yeah and the tiredness.

Q. Tiredness. The sputum?---

A. Yes.

Q. All those things have continued?---

A. Blood stained sputum."[24]

31 Mr McDonald submitted that before the plaintiff had the second lung function test her symptoms were so advanced and disabling that she knew its cause and diagnosis, which is consistent with her knowing of facts which constituted

[23] Transcript 35
[24] Transcript 36-37

knowledge on her part of serious injury incapacity.

32 Mr Ingram submitted that it was only after the second lung function test that Dr Fisher prescribed Spiriva, which he submitted is medication only, or usually, prescribed for emphysema.[25] The first prescription for it was made on 24 January 2008.[26] I will return to the medical evidence in more detail later in these reasons.

Diagnosis

33 Dr Fisher provided a report dated 13 November 2008 in which he referred to his diagnosis:

> "Ms. Pattison's symptoms were due to emphysema were, and are, chronic breathlessness, recurrent coughing with purulent sputum. She has sometimes notice blood stained sputum during these episodes.
>
> The treatment prescribed has been a regular Spiriva inhaler, with prednisolone and antibiotics for recurrent lower respiratory tract infections.
>
> The diagnosis is emphysema as proven on two lung function tests on 25th January 2006 and 7th January 2008. The description of emphysema was mild in 2006 and significant in 2008. Her emphysema has become worse due to the recurrent lower respiratory tract infections."[27]

34 Dr Fisher referred the plaintiff to Dr Sasse for treatment. Dr Sasse first saw the plaintiff in March 2009. He obtained a history of the plaintiff's exposure to cigarette smoke. He was aware that the plaintiff had undergone two CT scans, neither of which disclosed any significant changes in her lungs. He was aware that she was using Ventolin, Spiriva and Seretide to treat her lung condition. In a letter to Dr Fisher dated 5 March 2009, Dr Sasse seemed to be convinced that she was suffering from asthma.

35 Dr Sasse proposed to undertake a bronchoscopy on the plaintiff. In his letter dated 19 August 2009, he referred to undertaking the bronchoscopy. He

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25 That is in contrast to the evidence of Dr Trembath who accepted that Spiriva is used as a treatment for asthma: see paragraph 46 below

26 Exhibit 2

27 PCB 19

described the results of the bronchoscopy as follows:

> "I did proceed cautiously to bronchoscopy and the procedure itself went beautifully well and there was no abnormalities detected in her airways which is excellent."[28]

36 As a consequence of investigating the plaintiff's lungs, Dr Sasse appears to have been all the more convinced that the plaintiff was suffering from asthma. As a result, he devised an asthma action plan for her. Part of the action plan was a revision of the medication she was using. Dr Sasse did provide a report to the solicitors for the plaintiff dated 15 July 2010.[29] It does not add anything which is not otherwise referred to, then dealt with by him in the letters he wrote to Dr Fisher and Dr Edwards.

37 Dr Sasse's opinion, and the treatment he considered relevant, is at odds with the opinion of Dr Fisher. Although I have some residual concerns about the reliability of Dr Fisher's evidence, I should refer to some of it relevant to the two lung function tests undertaken by Dr Connor, physician, on 25 January 2006 and 7 January 2008. However, I will firstly repeat the results of each of the lung function tests.

38 In relation to the lung function test undertaken on 25 January 2006, Dr Connor reported:

> "Normal spirometric values, with no further significant acute bronchodilator response demonstrated. (although Pt. 'felt better'.)
>
> Carbon monoxide diffusing capacity is mildly impaired.
>
> Note: recent anaemia."[30]

39 In relation to the lung function test undertaken on 7 January 2008, Dr Connor reported:

> "Normal spirometric values, with no further significant acute bronchodilator response demonstrated.
>
> Carbon monoxide diffusing capacity remains sig. impaired. ? reason."[31]

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28 Exhibit 3
29 PCB 23-24
30 PCB 17

40 When Dr Fisher's attention was directed to the lung function tests, he said:

> "A. … Well I know when I came to the opinion. It was on the second lung function test on the 7th of January 2008 which showed significant – significant impairment in the carbon dioxide diffuser capacity.
>
> Q. Yes?---
>
> A. I thought aha, this must be more than just chronic asthma, it has to be emphysema. And so around about that time I think in the February '08 I prescribed her Spiriva.
>
> Q. Yes?---
>
> A. Which can - we're only allowed to prescribe for emphysema and not asthma, even though it is active against asthma. The pharmaceutical firm that makes it hasn't got an indication for asthma yet, it's only emphysema.
>
> Q. So that Spiriva, which began after that second lung function test?--
>
> A. Yes.
>
> Q. Was specifically for emphysema?---
>
> A. Yes, nothing else - we're not allowed to prescribe it for asthma, we're only allowed to prescribe it for emphysema.
>
> Q. All right, well since we are leaping ahead in bounds, maybe I'll just do it this way. There had been a suggestion following the first test, which was in January 2006 that there may be some emphysema present, do you - - - ?---
>
> A. There could've been but that - you see, she had asthma, chronic asthma which was disguising the problem too, you see. So it's a very difficult case, what really twigged it in my brain was the fact that it went from mild to significant."[32]

41 Dr Fisher also said that the significant impairment of carbon monoxide diffusing capacity led him to conclude what was demonstrated by the lung function tests could only be due to emphysema.[33] However, he accepted that the plaintiff had suffered from chronic asthma for many years. He said that he had to accept the word of Dr Sasse regarding the diagnosis of the plaintiff's lung condition, because he is a specialist in the area, that the plaintiff was suffering from chronic asthma and not emphysema.[34] It was particularly in

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31 PCB 18

32 Transcript 51

33 Transcript 53, 56, 63, 66, 68-69 and 72, and why he prescribed Spiriva at transcript 55

34 Transcript 63-65

this area where Dr Fisher appeared to me to drift from confirming his diagnosis of emphysema to then accepting that the correct diagnosis was asthma. It was largely because of that evidence that I reluctantly reached the conclusion that at least that part of his evidence was unreliable except where it was corroborated by other evidence, for example, his clinical notes and other evidence, such as, the lung function tests.

42 Whilst on the subject of unreliability, it is probably convenient to deal with a matter of confusion which I think is easily explained. I accept the plaintiff's evidence that Dr Fisher advised her of his diagnosis that she had emphysema after the second lung function test in 2008. I accept her evidence that Dr Fisher did not give her that advice after the first lung function test in 2006.[35]

43 Dr Burdon examined the plaintiff on 29 November 2010 and 19 April 2012. Dr Trembath examined the plaintiff on 3 March 2011 and 15 October 2012. Each were provided with a history of the plaintiff's exposure to cigarette smoke, the treatment provided by Dr Fisher and Dr Sasse, and reports, letters and clinical notes of both Dr Fisher and Dr Sasse which were tendered into evidence by Mr Ingram and Mr McDonald.

44 In his first report, Dr Burdon was of the following opinion:

> "I am of the opinion that Ms Pattison suffers from mild chronic airways disease predominantly of the mixed emphysematous and chronic bronchitic types. I note that Dr. Tony Sasse in his report dated 15 July, 2010 opined that Ms Pattison suffers from asthma. I would not agree with this opinion but do agree that there is a small degree of reversibility in her airways obstruction, particularly at the small airway level. This is entirely consistent with chronic airways disease."[36]

45 In his second report, he confirmed that opinion:

> "1 In my opinion, Ms Pattison suffers from mild chronic airways disease of the mixed emphysematous and chronic bronchitic types.
>
> 2 I am of the opinion that Ms Pattison's chronic airways disease has been caused by her passive exposure to cigarette smoking is the

35 Transcript 43-44.
36 PCB 32

workplace."[37]

46 Dr Trembath's opinion is very similar. I think it is sufficient to refer to his opinion in his second report.

> "In my opinion, the worker still suffers from asthma, and chronic bronchitis. On the basis of the reduced gas transfer, at 61% predicted, emphysema is, on balance, also a likely diagnosis."[38]

47 In relation to the prescription of Spiriva, he said:

> "Spiriva is being prescribed for her respiratory condition. While this is typically recommended for individuals with chronic obstructive airways disease, which may include emphysema, it is quite a common practice for respiratory specialists to prescribe Spiriva to assist with the symptoms of asthma … ."

48 Dr Trembath was asked to consider the opinion expressed by Dr Burdon relevant to diagnosis, and he said:

> "His diagnosis of chronic bronchitis is on the basis of the chronic productive cough. He includes emphysema on the basis of the reduced gas transfer. I think that this is quite a reasonable diagnosis to formulate."

Knowledge

49 Mr Ingram informed me that the plaintiff lodged her application for serious injury on 24 December 2010 . Therefore, the relevant date three years prior to 24 December 2010 is 24 December 2007. Therefore, she must establish that she did not have the relevant degree of knowledge until some time after 24 December 2007.

50 I am satisfied that the plaintiff had the relevant degree of knowledge before 24 December 2007. I have come to that conclusion after considering the evidence of the plaintiff, Dr Fisher, Dr Sasse, Dr Burdon and Dr Trembath, and having the benefit of the addresses made by Mr Ingram and Mr McDonald.

51 The medicine in this case is complex. However, what I have deduced from

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37 PCB 37

38 Exhibit C

the evidence is that the expression “chronic obstructive airways disease” is a term which is generic and which has been used to describe the impairment of function of the plaintiff’s lungs.

52 It is clear from my summary of Dr Fisher's clinical notes that between 6 June 2000 and 24 January 2008, the plaintiff was exhibiting symptoms consistent with a respiratory disorder, and very probably chronic obstructive airways disease.

53 Dr Fisher treated the plaintiff with medication, such as, Ventolin, Flixotide, Serotide, Zinnat and Prednisolone, which are medications used in the treatment of asthma. I am confident that is the case, because in the letters written by Dr Sasse,[39] he referred to creating an asthma action plan. That asthma action plan involved consideration of the use of Ventolin, Serotide, Symbicort, Prednisolone, Singulair and Q-Var.[40] Three of those types of medication were same as prescribed by Dr Fisher to treat the plaintiff’s asthma, and were being prescribed before the second lung function test.

54 It was after the second lung function test that Dr Fisher altered his diagnosis, but on my analysis of all of the evidence, he did not suggest that the generic term of chronic obstructive airways disease was not an appropriate clinical diagnosis.

55 The clinical term “chronic obstructive airways disease” was favoured by Dr Burdon and Dr Trembath[41] as a generic clinical term.[42] Both Dr Burdon and Dr Trembath discussed a number of possible/probable diagnoses, being asthma, bronchitis and emphysema, but they did so in the context of one or other or all of those as causes or contributors to the clinical processes contributing to the clinical diagnosis of chronic obstructive airways disease.

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39 Exhibit 3
40 Dr Sasse's letter to Dr Fisher dated 19 August 2009 in Exhibit 3
41 Exhibit C
42 PCB 37

56 The way in which the case was developed by Mr Ingram is that it was not until a diagnosis of emphysema was made that the plaintiff acquired the relevant knowledge. I reject that proposition. Firstly, it ignores the clinical diagnosis of chronic obstructive airways disease, and ignores the fact that the thrust of the diagnoses made by Dr Sasse, Dr Burdon and Dr Trembath include an attempt to determine the clinical process which caused or contributed to the diagnosis of chronic obstructive airways disease. Secondly, Mr Ingram criticised Dr Sasse's diagnosis of asthma, submitting that it was inconsistent with the balance of the medical evidence. Dr Fisher's evidence is that the plaintiff probably had asthma. Dr Burdon and Dr Trembath have not excluded asthma as being part of the plaintiff's clinical picture. Dr Trembath confirms that asthma is a relevant diagnosis, whereas Dr Burdon is of the opinion that the plaintiff suffers from chronic bronchitis rather than asthma.

57 The fact that the plaintiff did not have knowledge of the actual clinical process which caused or contributed to the diagnosis of chronic obstructive airways disease is not to the point. For example, if a worker suffered an injury to his lower back which might be due to a muscular or musculo-ligamentous or facet joint dysfunction or dysfunction of some other structure, it does not detract from a diagnosis that the worker suffered an injury to structures in the lower back resulting in an impairment of the function of the lower back which is long-term and which has consequences which are long-term. I do not accept that, in every case, it is necessary for the actual clinical process which caused or contributed to the injury to be identified when there is a sufficient clinical picture enabling a generic diagnosis to be made. In my experience, the latter is very commonplace in serious injury applications, and in damages trials where the impairment might not be capable of a precise diagnosis or where there is disagreement about the precise diagnosis, yet there is agreement that the worker suffered an injury described rather more generically.

58 The fact that the worker then discovers through an MRI scan that there is

discal involvement which the worker's medical advisers say is more likely to be the cause or contributor to the worker's lower back pain does not change the diagnosis, because it does no more than identify the clinical process which is causing or contributing to the injury, the impairment of the function of the lower back and its consequences.

59 It appears to me that Dr Fisher's clinical notes demonstrate that the plaintiff was labouring under major symptoms of an increasingly incapacitating chronic obstructive airways disease from 6 June 2000 onwards. It also appears to me that the severity of those symptoms were well-established before 24 December 2007.[43] By 2007, the plaintiff's evidence is that her symptoms were well-established and only progressed a little at a time thereafter.[44]

60 I am satisfied on the medical evidence up to that time, and confirmed particularly by the evidence of Dr Sasse, Dr Burdon and Dr Trembath, that if the plaintiff had made an application for serious injury before 24 December 2007, that she would have succeeded, because all of the elements necessary to prove that she had suffered an injury which resulted in a long-term impairment of the function of her lungs and long-term consequences were obviously present.

61 Mr Ingram submitted that the plaintiff's case is not dissimilar to that of Mr Rawlings in *Morris & Joan Rawlings Builders and Contractors*,[45] because it was not until there was a diagnosis of Mr Rawlings' mental or behavioural disturbance or disorder that he acquired the relevant knowledge. I do not accept that it is analogous to the plaintiff's case. The Court of Appeal made it clear that making a diagnosis of whether a worker suffers a mental or behavioural disturbance or disorder has its own peculiar problems:

> "If a worker loses a limb or is burned or deafened or damages his or her spine in the course of employment, the nature and extent of the injury

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43 I refer to the excerpts from the plaintiff's oral evidence reproduced at paragraphs 24-27, 29, and in particular at 30 above

44 The plaintiff's oral evidence reproduced at paragraph 30 above

45 *supra*

> and the incapacity of which it is productive are to a large extent obvious. If, however, a worker suffers a mental or behavioural disturbance, its existence, nature and extent may well go undetected. As Handley JA explained in *Commonwealth of Australia v Smith*, so much is really the inevitable consequence of the law's limitation of compensable mental problems to conditions which psychiatric medicine classifies as psychiatric injury. Although human beings may suffer all sorts of significant emotional and mental problems from time to time, neither they nor anyone else, short of a psychiatrist or psychologist is ordinarily likely to perceive the problem as arising out of a permanent severe mental or permanent severe behavioural disturbance or disorder. In most cases, it is only when and if they are so diagnosed that they are capable of knowing that the incapacity of which they were aware arises out of that condition."[46]

62 What the Court of Appeal observed is immediately distinguishable from the plaintiff's position. The plaintiff's position is rather more like the physical injury cases which the Court of Appeal referred to; that is, that her deteriorating lung condition was, to a large extent, obvious, and again, I refer to Dr Fisher's clinical notes and the opinions of Dr Sasse, Dr Burdon and Dr Trembath. I can well understand that the difficulty in determining whether a worker has a mental or behavioural disturbance or disorder is very different from a physical injury for reasons which the Court of Appeal commented upon.

63 In the end, I am satisfied that the plaintiff has failed to discharge the onus she bears which I referred to earlier in these reasons. I am satisfied that the plaintiff subjectively knew of facts at the relevant time before 24 December 2007 which, when viewed objectively at that time, means that she was suffering from the relevant incapacity before that date.

Conclusion

64 For the reasons set out above I dismiss the plaintiff's Originating Motion. I will now hear the parties on the question of the order that should be made and on the question of costs.

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[46] Paragraph 47. Footnotes excluded