District Court

New South Wales

Case Name:	McAlister v SAS Trustee Corporation
Medium Neutral Citation:	[2020] NSWDC 896
Hearing Date(s):	6 November 2020
Date of Orders:	26 November 2020
Decision Date:	26 November 2020
Jurisdiction:	Civil
Before:	Neilson DCJ
Decision:	Decision of the Police Superannuation Advisory Committee set aside. Plaintiff's pension be increased to 90% of the attributed salary.
Catchwords:	Police Superannuation – Abnormal risk benefit – Quantification of the benefit – Three certified infirmities: (1) left hallux rigidus (2) cervical spondylosis (3) sensorineural deafness – P was a member of Highway Patrol for most of his career and spent most of that time as a motorcycle rider – Extent of disablement apportioned as (1) 30% (2) 60% (3) 10% - Therefore of the 15% of salary of office available were (1) 4.5% (2) 9% (3) 1.5% - Allowed by Court was (1) 4% (2) 1% (3) nil – Base rate of 85% of salary increased to 90% of salary by findings of Court.
Legislation Cited:	Police Regulation (Superannuation) Act 1906 Workers Compensation Act 1987
Cases Cited:	Calman v Commissioner of Police (1999) 19 NSWCCR 40 Conway v SASTC [2012] NSWDC 249; (2012) 11 DDCR 212

	Green v SASTC [2013] NSWDC 200 SASTC v Green [2014] NSWCA 289
Category:	Principal judgment
Parties:	Plaintiff – Geoffrey McAlister Defendant – SAS Trustee Corporation
Representation:	Counsel: Plaintiff – M. Hammond Defendant – T. Ower Solicitors: D. Cabal (Carrol & O'Dea) L. Doyle (SASTC)
File Number(s):	RJ00424/19
Publication Restriction:	Nil.

JUDGMENT

1 HIS HONOUR: The plaintiff is a former senior constable of police. He was attested as a probationary constable of police on 25 August 1975 and thereupon became a contributor to the Police superannuation fund established under the *Police Regulation (Superannuation) Act 1906* ("the Act"). A year after being sworn as a probationary constable of police he was appointed a constable of police. The plaintiff initially performed general duties at Blacktown Police Station, but on 15 May 1977 was assigned to Highway Patrol duties, based in the Traffic Branch at North Sydney Police Station. He was later transferred to the Highway Patrol at Penrith and subsequently other places in Western Sydney.

2 The plaintiff last worked in November 2016 and went on sick report. He had made, on 11 August 2016, an application for discharge from the New South Wales Police on the ground of incapacity for work. The Police Superannuation Advisory Committee (PSAC) on 19 January 2017 certified that the plaintiff was incapable of performing the duties of his office on account of the infirmities of "hallux rigidus of the left great toe, cervical spondylosis and bilateral high-frequency sensorineural hearing loss".

3 On 31 January 2017 the Commissioner of Police certified that the plaintiff had injured his neck on 16 June 2015 and he had injured his left great toe on 22 July 1983 and 7 December 1990 and that he is suffering from a hearing loss which was notified on 4 September 2015. As a result of those certifications the plaintiff was medically discharged from the NSW Police on 9 February 2017 and was awarded a “hurt on duty” pension for the three infirmities to which I have referred.

4 In a subsequent decision PSAC determined that the plaintiff was totally incapacitated for work. The plaintiff then made an application for a benefit under s 10(1A) of the Act and on 30 May 2019 PSAC on behalf of the defendant determined to increase the plaintiff's HOD pension to 88% of the attributed salary of his office because in the opinion of PSAC the plaintiff was hurt on duty because he was required to be exposed to risk to which members of the general workforce would not normally be required to be exposed in the course of their employment, the test set out under s 10(1A)(c) of the Act.

5 Considering himself aggrieved by that decision, the plaintiff made an application to this Court by statement of claim filed on 4 December 2019. The hearing of this matter was conducted on Friday 6 November 2020, but so many documents were tendered that, by the end of the working day, I had no opportunity to give judgment. A problem was that in the following two weeks I was sitting on circuit in Lismore, hence I have listed the matter for judgment today. The reason or reasons which led PSAC to fix the plaintiff's entitlement under s 10(1A)(c) at 88% are not before me. I shall deal with each of the infirmities separately.

Left hallux rigidus

6 The first infirmity has been specified as "hallux rigidus" of the left great toe. That is a pleonastic title. “Hallux” is the anatomical word for the great toe. It is merely necessary to certify left hallux rigidus. ‘Rigidus’ just means rigid or fixed, so that it just means a condition of having a fixed or rigid great toe. The cause of the great toe problem is clear to me. It is the event of 22 July 1983. On 25 July 1983, the plaintiff completed a report of injury form. It can be found in exhibit LL, p 19. It tells me that on 22 July 1983 at approximately 1pm the

plaintiff was riding an unregistered motorcycle in the dirt section of the track at the Saint Ives Driver Training Centre as part of his involvement in High Speed Cycle course number 425. The claim form goes on to say this:

> "I negotiated a right-hand bend of the front wheel of the cycle, lost traction in the sand causing me to fall off the cycle and in so doing, the cycle fell heavily on my left foot."

The description contains a patent error. The bend was a left-hand bend. The plaintiff clearly made a mistake often made by medical practitioners which leads to a cause of action for professional negligence.

7 On 27 October 1983, the plaintiff made a further report. It contains this matter:

> "1. On Monday, 18 July 1983 I attended a high-speed motorcycle course at Saint Ives Driver Training School, the course concluding on 12 August 1983. The hours of duty were 7.30am to 2pm, Monday to Friday.
>
> 2. On Friday, 22 July 1983, I was riding a Departmental trail bike along a dirt track, under the supervision of Senior Constable Baldwyn. Whilst negotiating a left-hand bend, the front wheel slid in the sand, causing me to lose control of the motor cycle. I attempted to regain control, but I was unable to do so and as a result, I fell with the motorcycle to the ground. I landed on my left side and the cycle fell on my left foot. I felt a sharp pain to the heel and front of my foot. I took off my left police issue boot and found a graze to my heel and slight swelling and tenderness to the joint of my big toe.
>
> 3. The incident was witnessed by Senior Constable Baldwyn, who shortly after made an entry on the occurrence pad at the training centre, entry number 83/21.
>
> 4. I did not seek medical attention at the time, as it was considered that it was only bruising, and the swelling would go down. Fortunately, the pain to the joint went after a couple of days, but the swelling remained. I did not go off on sick report as a result of injury.
>
> 5. On 5 September 1983 I attended the First Class Constables course, which is held at the Police Academy, Elizabeth Street, Redfern. The course is a one-month course. I had to walk about one kilometre a day from the railway station at Redfern to the Academy over that period of time and I found that the pain returned to the joint of my left foot.
>
> 6. On 11 October 1983, whilst on annual leave, I attended my local doctor, Dr Andrew Csillag of 88 Oxford Street, Cambridge Park, for examination of the injury. On the same day I went to Castlereagh Street, Penrith and had the foot x-rayed. The doctor informed me that the joint is normal and gave me medication to remedy the situation..."

The same document was also tendered in the defendant's case and is exhibit 1.

8 A handwritten report from Dr Csillag tells me that the plaintiff consulted him on 11 October 1983 and gave him a history consistent with what I have quoted. Dr Csillag refers to the x-ray as being "normal", but there are subsequent views which indicate otherwise.

9 In addition to relying on the event of 22 July 1983, the plaintiff also relies on the event certified by the Commissioner of Police, that of 2 December 1990. Exhibit 2 is a report of injury made by the plaintiff on P124b form. That says that on Friday, 7 December 1990 the plaintiff was working at the Mt Druitt Police Station. By that time he had been appointed a Senior Constable of Police. The narrative in Exhibit 2 continues thus:

> "An offender was seen exceeding the speed limit, the offending vehicle stopped prior to radar stop vehicle. Senior Constable Hedges, approached the offender and a foot pursuit ensued. I then assisted Senior Constable Hedges in the arrest of the offender. During the struggle the offender was forced to the ground and his arms forced behind his back. I was leaning on my left knee with my toes hard to the ground. The offender was then pulled up from the ground after being handcuffed and I felt a twinge in my lower back. I then drove back to the police station. Upon arrival at the station I alighted from the police vehicle and when I stood up I felt a sharp pain from my big toe knuckle of my left foot (recurrence of previous HOD injury)."

10 There is a further description contained on p 23 of exhibit LL. The important thing is the time of the onset of pain. That document contains this matter. It is a report bearing the date 17 December 1990:

> "3. A strugglers you between the offender, Hedge and myself. The offender was forced to the ground, face first. The arms of the offender were forced behind him and handcuffs placed on his wrists. I was over the top of the offender, leaning on my left knee and my left knee and my left foot was pointing to the ground. At the time I had pressure on that foot. The offender was pulled up off the ground once the handcuffs were placed on his wrists.
>
> 4. The offender was then placed into the rear of the police vehicle and conveyed to the Mount Druitt Police Station. I returned in another police vehicle. Upon my return I parked the vehicle and got out. I stood up and felt a sharp pain coming from the knuckle of my left big toe. I had difficulty walking from the police vehicle to the rear entrance of the

police station. I removed my boot, but the pain still remained, but not as intense.

5. Also as a result of the arrest I sustained some pain in the lower back region when the offender was pulled up off the ground at the scene.

6. I attended on the 8 December 1990 and consulted my local doctor in relation to the injuries. I was issued a certificate for three days with trauma to the left big toe. I was also given a referral to have the toe x-rayed. I attended 109 Lethbridge Street Penrith and had the left big toe x-rayed...[The plaintiff recited the x-ray report]...

7. I have suffered periodic pain to this injury but has not been severe enough to cause any time off work, until now. Whilst working and during everyday living, I do suffer from varying degrees of pain and discomfort as a result of the injury. But at this stage, the injury doesn't appear to be affecting my duties."

Other records in exhibit LL tell me the plaintiff was off work for three days between 8 December and 11 December 1990 and that the Commissioner of Police accepted that that was because the plaintiff was hurt on duty.

11 The question is when was the "injury" or the "hurt" to the left hallux received? If one has a persisting injury, which the plaintiff clearly had since 22 July 1983, seven years earlier, then the mere fact of standing up on the toe when it had not been weight bearing might be enough to trigger off some symptoms or cause an aggravation. Clearly there was an aggravation, but it persisted for only three days. The x-ray report makes it clear that there was longstanding pathology, but no recent pathological change, such as fresh fracture or like. Everything points to this being a continuing problem and that what occurred when the plaintiff stood up, after getting out of his car on 7 December 1990 is merely a temporary aggravation, a demonstration of the underlying pathology.

12 It should also be noted that in addition to putting in a claim for an injury to his left foot, the plaintiff also made a claim for a recurrence in an event that occurred on Thursday, 14 March 1991 when was off work. He went to a motorcycle repair shop at Penrith to have his personal motor cycle inspected for registration. Whilst he was there, he knelt down to check the adjustment of the front brake and when he stood up he felt a sharp pain in his left great toe. That clearly did not arise out of or in the course of his employment, but in accordance with the decision of the High Court of Australia in *Calman v Commissioner of Police* (1999) 19NSWCCR 40, it would still be compensable,

because the aggravation or the like of a pre-existing work-related condition remains compensable even if the circumstance of aggravation or the like was not directly duty caused.

13 The plaintiff also reported a similar incident which occurred on Saturday, 4 December 1990 at his home when he was having a birthday party for his wife. During the course of the day the plaintiff was constantly on his feet working around the house for the party and during the party in the evening he felt increasing discomfort in his left great toe.

14 I turn now to certain medical evidence concerning the condition of the plaintiff's left hallux. The x-ray report made at the request of Dr Csillag on 11 October 1983 is not before me. However, they were referred to by Dr John Ireland under whose care the plaintiff came in early 1991. In Dr Ireland's report of 9 March 2001, he said that he saw the x-rays of 11 October 1983 and that they showed "minimal joint space narrowing and some minor lateral metatarsal spurs." There were further x-rays performed on 23 July 1987. They are referred to by Dr Thomas Claffey who saw the plaintiff for the defendant on 28 March 2000. In his report he said this:

> "I noticed in his submission of September 1987, he said that due to persistent discomfort, he had further x-rays taken on 23 July 1987. I have seen these films. I consider that they did not show much of significance, although I note the x-ray report, which Mr McAlister has included which states that there is a degenerate change at the metatarso-phalangeal joint with the small osteophytes arising from the joint margins. He says that these appearances were seen in the previous study of 1983."

The "he" in the last sentence clearly is a reference to the radiologist reporting on the films, rather than the plaintiff. However, they would appear to suggest that the initial x-rays were abnormal.

15 There was also an x-ray performed on 10 September 1990, although the date is not clear - it may be 10 December 1990. It was received by the New South Wales Police on 2 January 1991. The quality of the photocopy is extremely poor at least as far as the top of the document is concerned and the date is extremely difficult to read. However the report is this:

> "There is degenerative change in the metatarso-phalangeal joint of the big toe with subarticular sclerosis and slight irregularity of the articular surfaces. There is no other abnormality. There is no evidence of a fracture. On comparison with the films of 23 July 1987 there has been some progression of the degenerative changes with further narrowing of the joint space."

If the date of that x-ray is 10 December 1990 then clearly that shows advanced degeneration since 23 July 1987, but as I earlier mentioned, no recent bony injury. It does mean that the osteoarthritis in the metatarso-phalangeal joint was progressing and increasing.

16 That led undoubtedly to the referral of the plaintiff to Dr John Ireland who first saw him on 29 April 1991 at the request of a Dr Wilson from Cambridge Park. The fullest description of the history given by the plaintiff to Dr Ireland is not contained in his report of 30 April 1991, but in his report of 9 March 2001. It is this:

> "On 22 July 1983, he was riding a trail bike along the dirt track and as he negotiated a left-hand bend, the front wheel slid in some sand and he lost control of the motorcycle. The motorcycle fell to the left and he caught his left foot and lower leg between the ground and the motorcycle. He noted a sharp pain the foot at that time.
>
> He noted some swelling and tenderness to the big toe but continued riding that day.
>
> He had difficulty walking after the incident but it did not prevent him from completing the cycle course. He did not seek any medical attention at the time and the pain settled after a couple of days. He did note however that the swelling remained.
>
> While working in Redfern in September 1983 he found that long walks between the train station and the call centre led to some discomfort in his left great toe. He eventually say his general practitioner, Dr Andrew Csillag at Cambridge Park and had x-rays carried out on that left big toe. He was apparently given some medication at that time.
>
> He had some further problems in 1987 with periodic pain in cold weather and walking long distances.
>
> In 1990 after assisting in apprehending an offender he noticed some pain in the great toe and had difficulty walking from his police vehicle to the entrance of the police station.
>
> On 8 December 1990 he was seen by his local doctor and given three days off work.
>
> He saw Dr Kathleen Wilson and was referred to myself."

This is a consistent history. In his report of 30 April 1991 Dr Ireland said this:

> "X-rays showed a progression of degenerative changes in the joint since 1983.
>
> It would appear this gentleman has osteoarthritic changes in his left first metatarso-phalangeal joint as a result of trauma sustained in 1983. I think in the first instance he would benefit from a debridement of this particular joint. If, however, the joint is significantly destroyed, then he may require arthrodesis."

17 That was a prescient prognosis, because on 21 March 2017 the plaintiff underwent an arthrodesis of the metatarso-phalangeal joint of his left great toe. Lest anyone not know the anatomy of the foot, the metatarsals are the long bones that constitute the arch of the foot stretching from the heel to the toes and each segment of the toe is called a phalanx and the metatarso-phalangeal is the first joint of a toe, the joint between the metatarsal bone and the first phalanx of the toe.

18 On 28 June 1990 the plaintiff underwent debridement. Dr Ireland refers to that process a cheilectomy. That is only a lovely Greek name for the Romance debridement. Dr Ireland's report of the surgery is this:

> "Extensive osteophyte formation was noted around the head of the first metatarsal and also to a lesser extent the proximal phalanx. There were two small areas of eburnated present on either articular surface and a small ulcerated area measuring approximately three or four mm in the centre of the metatarsal head. The osteophytes were trimmed and the ulcerated area debrided.
>
> Post-operative instructions were to rest and elevate the limb and to mobilise as comfortable. Discharged home on crutches and to be seen in 10 days time."

The plaintiff was then prescribed physiotherapy but as late as 12 September 1991 the doctor did not think the plaintiff would be able to wear his police boots. However, on 10 October 1991 Dr Ireland cleared the plaintiff to return to his normal duties.

19 Although the doctor’s treating reports all suggests that the pathology resulted from the event of the 22 July 1983, there is an alternative view expressed by Dr Ireland in his report of 9 March 2001. That report is addressed to a solicitor and it is clear that the doctor was qualified on this occasion. He examined the plaintiff on 9 March 2001. His report contains this matter:

> "A sequence of x-rays was available. Those of 11 October 1983 showed minimal joint space narrowing and some minor lateral metatarsal spurs. Further x-rays of 23 July 1987 revealed no significant change. Those taken on 1 December 1990 showed increasing joint space narrowing and spurring. The most recent x-rays of 6 June 2000 showed marked joint space narrowing and spur formation.
>
> In Summary
>
> This gentleman has sustained a traumatic osteoarthritis of his left first metatarso-phalangeal joint as a direct result of the accident sustained t work on 22 July 1983."

The doctor went on to diagnose a 25 per cent loss of efficient use of the plaintiff's left leg "at or below the knee."

20 A number of doctors have expressed that view or a view that the plaintiff has a loss of efficient use of the left leg below the knee, which is the correct test, which is properly quoting one of the items in the Table of Maims that used to exist under s 66 of *Workers Compensation Act 1987*. However, it appears to me the correct item to assess is the loss of efficient use of the foot. There is some assessment of the loss of efficient use of the great toe, but clearly the metatarsal head is involved as well, so the thing that ought be addressed is the loss of efficient use of the foot.

21 Although that report says that the problems result from the event of 22 July 1983, Taylor and Scott raised a further question of the doctor and which led him in a report of 25 November 2002 to say this:

> "I would state that the initial injury led to the onset of osteoarthritis in the left great toe and the latter injury on 7 December 1990 led to a substantial aggravation, which precipitated the need for surgery."

With unfeigned respect to Dr Ireland, I cannot agree with that formulation. There was an aggravation due to the event of 7 December 1990 that appears likely that it caused an aggravation that persisted for all of three days. However, x-rays taken at that time clearly suggest that the plaintiff's problems were even worse. There was no immediate need to refer the plaintiff to Dr Ireland. That happened in the following year. In the same report of 25 November 2002 Dr Ireland attributed 40 per cent of the loss to the event of 7 December 1990, but in my view that is completely extravagant and inconsistent with the other evidence.

22 There are before me a large number of other opinions which clarify things to a slight extent. The first is a report of Dr Claffey following upon his examination of the plaintiff for the defendant on 28 March 2000. I have also already quoted some of what Dr Claffey says about the x-rays. Dr Claffey's opinion contains this:

> "Mr McAlister has bilateral hallux rigidus. This is usually a constitutional condition. However, in this particular instance, aggravation from the motorbike accident cannot be denied to the symptoms and x-ray changes on the left side.
>
> His present and continuing symptoms are due to the underlying degenerative changes in the left first metatarso-phalangeal joint and the aggravation of the motorbike accident. I have to consider that the motorbike accident is the main cause of his continued problems on the left side."

There are other opinions to the same effect, although subsequent opinions often emphasise the bilateral nature of the problem and minimise the impact of the event of 22 July 1983. The plaintiff clearly has bilateral hallux rigidus. That is a constitutional condition affecting each great toe. However, there is no suggestion that at any time the right great toe has caused the plaintiff any problems at all. Clearly, the major cause of the problem with the plaintiff's left great toe, which eventually led to the arthrodesis, was the effect of the injury of 22 July 1983.

23 However, the existence of the pre-existing constitutional condition explains why some abnormality was found in the initial x-rays taken so soon after the event of 22 July 1983, on 11 October 1983, less than three months later. For any frank injury to cause bony reaction there must be about six months for it to occur and here there was x-ray evidence suggestive of some minor degenerative problem in the initial x-rays taken within three months of the event. However, as I say, the extent of the input of the underlying condition is small. It only represents some propensity to develop a problem if the joint be damaged.

24 Another opinion has been provided by Dr Anthony Hodgkinson, like Dr Ireland and Dr Claffey, an orthopaedic surgeon who saw the plaintiff on 3 March 2003, again for the defendant. Dr Hodgkinson's opinion is this:

> "This man has progressive evidence of osteoarthritic degeneration which I believe has been initiated as a result of the incident on 22 July 1983. There may be an element of constitutional degeneration independent of this injury, but of a minimal degree as he has similar early changes clinically on the right first metatarso-phalangeal joint. There is no mention of any additional injury to the left toe on 7 December 1990. However, progressive x-rays taken over the years as reported in my history demonstrate that this is progressive hallux [rigidus] condition as a result of the osteoarthritic changes in the left great toe in the metatarso-phalangeal joint. As stated in Dr Claffey's report this often is related constitutionally to bilateral pathology in the first toe, but in this instance I believe most of the degenerative changes, as described by Dr John Ireland in his operative report are the result of the initial trauma on 22 July 1983. I believe that Dr Hodgkinson's summary is fair and accurate."

25 Yet another opinion was provided to the defendant by Dr Paul Hitchen, also an orthopaedic surgeon, who saw the plaintiff for the defendant on 6 May 2003. Fortunately he confirms that the x-rays of 1990 were made on 10 December 1990, not on 1 December 1990. His opinion was this:

> "The diagnosis is bilateral hallux [rigidus] and osteoarthritis of the great toe MTP joints. Normally, this is constitutional in nature and unrelated to trauma. Needless to say, there is a clearly documented history of recurrent injury to the left great toe. If one uses the degenerative change present on the right great toe as a base line, there is a clear difference between the two sides and thus the more dramatic clinical signs and symptoms on the left can be attributed to the injuries in question. That is to say, the injuries of 22 July 1983 and 7 December 1990 caused a permanent exacerbation of his pre-existent and evolving osteoarthritis."

Again, I point out that I find statements that the event of 7 December 1990 was a permanent aggravation or permanent exacerbation too far outside a proper analysis of all the evidence. In a supplementary report Dr Hitchen expressed the view that a quarter of the pathology in the plaintiff's right foot should be attributed to the pre-existing pathology, but again I believe that overstates the input of the pre-existing condition.

26 On 23 March 2016 the plaintiff was sent by a general practitioner at Cambridge Park, Dr Singham, to see Dr Todd Gothelf, an orthopaedic surgeon, practising with the Ortho Sports practice at a number of places. It appears that Dr Gothelf saw the plaintiff at Penrith. Dr Gothelf commences his first opinion with this paragraph:

> "Mr Geoffrey McAlister is a 60 year old male with a first MTP joint arthritis. I have discussed options of treatment with him, non-operatively he can try rigid sole orthotics and operatively I would consider a first MTP joint fusion with bone graft. Surgery would involve six weeks in a wooden shoe, screws are left in the bone permanently and six months swelling. He would have an 85 per cent chance of success."

However, surgery was not practised until 21 March 2017 because the plaintiff had undergone three coronary artery stent insertion in November 2015 at the hands of his cardiac surgeon and that caused a delay in the performance of the surgery.

27 In a report of 28 February 2017 Dr Gothelf said this:

> "Geoffrey is here to follow up his left foot first MTP arthritis. Surgery was delayed to his heart condition. According to his cardiologist, he can proceed with surgery now. Plavix will be discontinued, 2-3 weeks around the time or surgery.
>
> He still wants the surgery done. According to Geoffrey, he is not on Plavix, only on aspirin.
>
> Geoffrey is a 60-year-old with first MTP arthritis. Now cleared by cardiology, we will go ahead with first MTP fusion..."

The doctor then set out what he previously stated to the general practitioner. The fusion with bone grafting was performed at the Nepean Private Hospital on 21 March 2017. The last report before me from Dr Gothelf bears the date 16 August 2017, five months after the surgery. According to Dr Gothelf, the fusion was solid. He permitted the plaintiff to resume walking and playing golf and going to the gym, provided he had no pain. He was pleased with the results of the surgery but was happy to see the plaintiff again if the need arose. However, the plaintiff must have had some symptoms because Dr Gothelf supplied a cream to help with a feeling of burning pain in the toe.

28 There have been further recent opinions concerning the plaintiff's left great toe. The first is from Dr Giblin who the plaintiff was sent to see by a solicitor. Dr Giblin saw the plaintiff on 6 August 2016 but that, clearly, was prior to surgery. It is Dr Giblin who told me about the three coronary artery stents being inserted in November 2015. Dr Giblin provided this diagnosis:

> "Based upon his history and examination, he has a provisional diagnosis of soft injury to his left big toe primarily related to the subject injury 22 July 1983 and undergoing progressive deterioration based

> upon the general nature and conditions of his work environment as the main contributing factor."

That might be relevant to a claim in the Worker's Compensation Commission but hardly currently relevant. It suffers from a number of implausibilities. Firstly, the aggravation of osteoarthritis is not a "soft tissue injury". Secondly, a policeman working in the highway patrol sits in cars or rides on motorcycles. Doing general duties would be more disadvantageous to the plaintiff than working as a highway patrol officer, where he might have, for example, to pound the beat or chase offenders on foot or generally do a lot of walking. Thirdly, every human being walks in the course of their non-work activities and weight-bears on their feet in various stages of their existence. So attributing the progression of the plaintiff's condition to the type of work that he was doing indicates the doctor had not considered the nature of the work seriously enough.

29 Doctor Giblin reassessed the plaintiff for his current solicitor on 16 July 2009. In his report of 17 July 2019, Doctor Giblin said this:

> "This gentlemen has the diagnosis of an injury to his left big toe commencing in the course of his duties 22 July 1983 and then undergoing further injuries September 1983, 7 December 1990, 27 June 1991 and 4 June 2000, together with the nature of conditions of his employment in the NSW Police Force."

What the doctor is referring to by the injury of 7 September 1983 appears to be the walking between Redfern Police Station and the Police Academy, which is not on Elizabeth Street but closer to South Downing Street in Darlinghurst, when he was attending the first class constables course. The event that occurred on 27 June 1991 might be a reference to the surgery performed by Dr Ireland on 28 June 1991. The event of 4 June 2000 is not an event pleaded in these proceedings or relied upon but can be found on p 4 of exhibit A. Which contains this matter:

> "On Sunday 4 June 2000, about 6.30am I attended the intersection of the Horsely Drive and Nelson Street, Fairfield, to assist another officer to perform traffic point duties in relation to a fatal motor vehicle accident. I was standing for about one hour and at the time it was fairly cold. During the day I felt increasing pain to the left toe area whilst walking. I failed to complete my rostered shift."

It is quite clear why the plaintiff does not rely upon this event. Firstly, it is not certified by the Commissioner of Police. Secondly, it is not pleaded in the statement of claim. And thirdly, one wonders how the requirement to stand or walk carries a special risk that members of the ordinary workforce are not exposed to. In any event, it appears to me to be merely a demonstration of the underlying pathology. I am of the view that Dr Giblin's reports do not assist me.

30 The plaintiff saw Dr Michael Shatwell, an orthopaedic surgeon for the defendant. He saw the plaintiff on 25 November 2016 in reference to the left great toe injury of 22 July 1983 and the neck injury of 16 June 2015. It would appear that Dr Shatwell was qualified by the defendant for the purpose of giving medical advice to PSAC. As far as the left hallux rigidus was concerned, the doctor described it as a condition which was of gradual onset over many years and believed that the injury of 22 July 1983 "may have exacerbated the condition." The use of "may" is a gross understatement as fair as I am concerned. As far as the future was concerned, Dr Shatwell thought that there was no improvement likely and he also referred to the possibility that the plaintiff might be treated by arthrodesis, which in fact came to pass later, that even if the arthrodesis ameliorated the pain the stiffness in the joint would remain and "make rapid movement different, if not impossible."

31 The final opinion about the plaintiff's left hallux rigidis is provided by Dr Vijay Panjratan, again an orthopaedic surgeon also qualified by the defendant. This would appear to be in respect of the plaintiff's claim for lump sum compensation pursuant to s 12D of the Act. The doctor was asked a number of questions but most of the answers are self-explanatory. One p 6 of his report the following is stated:

> "The left great toe was injured when a trail bike fell on him during a training course. The toe gradually became worse with time and subsequent injuries. He developed osteoarthritis and the joint was fused on 22 March 2017. The pain settled after the fusion.
>
> The toe is fused and stable now. Further change is not expected.
>
> The fusion of the toe has been beneficial with a loss of pain but a loss of great toe movements which should have little impact on the claimant's ability to work, domestic or leisure activities."

He went on to diagnose a 15 per cent loss of efficient loss of the left leg below the knee “involving the whole of the left leg.” Again the doctor did not know exactly what the Table of Maims required.

Neck

32 I turn now to consider the consideration of the plaintiff's neck problem. On p 29 of exhibit LL is an incident notification form completed on 16 June 2015 at 9.19 am. That tells me that the incident occurred on 16 June 2015 at 8.50 am. The plaintiff was at that time a member of the Traffic and Highway Patrol. The incident occurred at Penrith when the plaintiff was undergoing training. The brief description given in that document is this:

> "The incident occurred whilst conducting defensive tactics trainings. Geoffrey was being leg swept by another officer and has landed awkwardly. He has complained of a sore neck and lower back. "

The incident was reported to Mr Perry Halverson. A fuller description is contained in the complainant's claim for hurt on duty's benefits, dated 19 June 2015, which is exhibit 6. It contains this description of how the event occurred:

> "On Tuesday, 16 June 2016, Senior Constable McAlister attended the annual DEFTAC accreditation at Penrith, rostered duties 0700-1600. Prior to the commencement of the DEFTAC lessons, Senior Constable McAlister has complied with the safety brief and injury declarations and participated in the warm-up drills. It was during leg sweep drills the Senior Constable McAlister has fallen back and suffered an injury to his neck. Senior Constable McAlister was assisted to his feet and was not able to continue with the scheduled lesson plan for the day. He was conveyed home by Weapons Training staff and attended a doctor in Penrith."

The witness is described on this occasion as Perry Halverson of Penrith Weapons Training.

33 The plaintiff was cross-examined about pre-existing problems in his neck. Relevant documents are in exhibit 5. However, they are also mirrored by entries in the plaintiff's NSW Police medical record which are contained exhibit LL commencing at p 5. Exhibit 5 is a series of certificates. The first is from Dr Andrew Csillag and is dated 24 January 1983. It certifies the plaintiff as being unfit to resume work from 24 January 1983 until 29 January 1983 on account of musculoligamentous neck pain. The medical records indicate the plaintiff took sick leave during that period. There are two certificates from Dr Csillag,

one dated 9 July 1984, the other dated 24 July 1984, which certified the plaintiff is unfit for work from 9 July 1984 until 23 July 1984. The first certificate refers to soft tissue neck injury and the second certificate refers to "neck pains". However, it is clear from the police medical record that that was because of a hurt on duty injury which was recorded as having occurred on 7 July 1984. The final certificate bears the date 30 March 1988 and certify the plaintiff was unfit to work for five days from 30 March 1988 to 4 April 1988 and is clear that that was sick leave. These appear to be relatively minor events in the 1980s and here I am dealing with an event that occurred on 16 June 2015, over 25 years later. One can understand the plaintiff may have forgotten after a quarter of a century having some minor neck pains in the 1980s.

34 The human spine is only fully developed by the age of 26 to 28 years. Once fully developed, it starts slowly to degenerate. Cervical spondylosis can be described as either degenerative disc disease or osteoarthritis of the neck. My preference is to describe it as degenerative disc disease. It is clear that the degenerative disc disease pre-existed the event of 16 June 2015. However, it is clear that there was an aggravation of that condition caused by the event of 16 June 2015 and that aggravation continues to affect the plaintiff and is likely to be indefinite.

35 The plaintiff was sent by Dr Rahman, a doctor at the Healthsmart Medical Centre in Penrith, to see Dr Behzad Eftekhar, a neurosurgeon at Macquarie Neurosurgery, at which the doctor's rooms, though, is unclear. The doctor first saw the plaintiff on or about 27 July 2015, about a month after the event. Dr Eftekhar's report as provided by me is almost illegible. However, it is clear however the plaintiff was not challenged on the event referred to in the documentation, which I have quoted. I assume the history given by the plaintiff to Dr Eftekhar is consistent with what is contained in the documentary evidence. Dr Eftekhar referred the plaintiff for an MRI scan of his brain and his cervical spine. That is reported as showing mild disc disease at C3/4, C4/5, mild to moderate disc disease at C5/6 and moderate disc disease at C6/C7, but only minimal disc desiccation at C7/T1. At C5/6 there was said to be dural indentation and mild deformity of the spinal cord although with normal signal at

that level. There was no spinal canal stenosis shown. The radiologist has summed up the report thus:

> "1. Multilevel mild to moderate disc disease predominantly involving C4/5-C6/7 levels where there is mild kyphosis.
>
> 2. C5/6 level shows moderate disc disease with mild kinking of the spinal cord without signal change. Moderate right C5/6 foraminal narrowing due to uncovertebral disease. Mild uncovertebral disease is present elsewhere."

36 The plaintiff returned to see Dr Eftekhar on 3 September 2105. Dr Eftekhar said this:

> "The MRI does not show sinister neural compression and certainly does not need neurosurgical intervention. However, there is a reversal of cervical lordosis and significant degenerative changes and facet arthropathy, which explains his severe neck pain.
>
> I had a detailed discussion with Geoff. I explained the findings and encouraged to maintain proper spinal care and continued isometric neck exercises."

37 I have no further opinions from Dr Eftekhar. I do, however, have Dr Shatwell's assessment of 25 November 2016. I have already quoted Dr Shatwell's assessment of the plaintiff's left hallux. Dr Shatwell diagnosed cervical spondylosis which had been aggravated by the event on 16 June 2015. He said that no improvement was likely and expressed this prognosis concerning the neck:

> "The prognosis for cervical spondylosis are is for intermittent pain with a restricted movement and a susceptibility to re-injury with physical stress in situations requiring rapid head and neck movements to follow the progress of developments threatening public order."

In other words, the doctor was indicating that the prognosis was guarded and that there was a real possibility of further injury if the plaintiff performed the normal sort of work of a police officer.

Deafness

38 I turn to consider the plaintiff's claim in respect of sensorineural deafness. Sensorineural deafness was originally called boilermakers' deafness. It used to be referred to in workers compensation legislation as boilermakers' deafness or deafness of the like origin. It can also be referred to as industrial deafness. It is caused by exposure to noises exceeding 85 decibels. A very loud noise such

as an explosion can cause a traumatic deafness; that is, sensorineural deafness induced by one major noise rather than success of small noises over a protracted period of time. It is clear that every one diagnoses what I would refer to as boilermakers' deafness.

39 The documentation before me indicates that the plaintiff's exposure to noise and the existence of some deafness was reported on 4 November 2015. It appears to me that the claim for compensation for that condition there is a subsequent date. However, the Commissioner of Police has accepted that the deemed date of injury for the boilermakers' deafness was 4 November 2015. The first evidence of the deafness is an audiogram which is undated. It would appear to be the "recent" audiogram referred to by Dr Singham in a report of 25 October 2015, addressed to the NSW Police Claims Manager. That was received by the Police administrative officers on 29 October 2015. The audiogram, whilst undated, and whilst not quantifying the deafness does show a pattern fairly consistent with boilermakers' deafness. Dr SIngham in his letter to the Police indicates that it showed moderate sensorineural hearing loss in each ear.

40 I have a large number of opinions concerning the deafness. The first is a report from Dr Niranjan Sritharan, an ear, nose, throat, head and neck surgeon. He had this history:

> "Geoffrey reports long-term noise exposure through his work in the police force. There are no specific incidents I am able to describe, but it is more likely cumulative noise exposure that may have been a factor in hearing deterioration.
>
> Other social and recreational noise exposure over the years would have exacerbated his current hearing decline. Furthermore, a genetic predisposition to hearing loss is also relevant in patients. I do not have specific information in either of these aspects with regard to Geoffrey."

This opinion is completely unhelpful. The doctor's job would be to ascertain that there was a family history of deafness so he could work out if there was any genetic input and his job also would require him to ascertain what noise exposure there may have been outside of the plaintiff's work.

41 The next opinion I have relevant to this issue is that of Dr Henley Harrison, who examined the plaintiff on 23 February 2016 in Macquarie Street and prepared a

report dated 1 March 2016. Dr Harrison is an ear, nose and throat surgeon. Dr Harrison very properly took a family history. The only family history was of the plaintiff's mother being deaf in her 80s. Deafness in extreme old age was thought by Dr Harrison to be irrelevant, and very rightly so. Presbycusis is a natural deterioration of hearing due to age.

Dr Harrison took this history:

> "From the time that he joined the police force until he joined the Traffic and Highway Patrol on 15 May 1977, he was on general duties. On general duties he was exposed to some siren and alternating horn (klaxon) noise for possibly 30 minutes a day. He has continued as a member of the Traffic and Highway Patrol until the present time. (he is still working for the Force) and in 1983 started riding motorcycles on duty. His Traffic and Highway Patrol time exposes him to more siren noise [than] general duties and, of course, the motorcycle noise. Despite his wearing a helmet, which would mitigate somewhat the noise from the motorcycles and sirens, I believe that exposure to such noise over the working day would have the tendencies, incidents and characteristics such as to have the potential to damage hearing.
>
> In addition to the above sources of noise, Mr McAlister's time with the Force has exposed him to the noise of annual pistol shooting practice at which he would usually fire about 100 rounds fired by himself, plus the noise of the guns when fired by others. Initially, no hearing protection was worn, but more recently there has been hearing protection provided.
>
> Mr McAlister is also exposed to the noise of police wireless communications in his helmet, the level of which he can adjust, but I doubt whether this is made any significant contribution to the potential for hearing damage, because it would be unlikely that it was adjusted to be uncomfortably loud.
>
> Very occasionally Mr McAlister has been exposed to unprotected gunfire noise outside of the annual shooting practice when he has had to euthanase an animal, but this seems to have only been a very few occasions and is probably not made much contribution to any potential for occupational hearing loss.
>
> Mr McAlister mentioned an incident on 29 November 2002 when he was assaulted and sustained trauma to the right side of the head. He said that he was stunned but not knocked out and that this did not seem to affect his hearing. There is no indication from the hearing test obtained that there was any significant effect on hearing due to this and because of this and Mr McAlister not noticing any effect, I believe that the hearing was not affected and that this is irrelevant to the claim.
>
> Mr McAlister has no noisy pastimes, but he did spend about two years in the Australian Army Reserve, but he only went to the rifle range twice

> and had no other noise exposure. Hence I believe that any noise exposure from this military service was negligible and must be irrelevant to the claim."

42 I should say that a number of other ENT specialists have obtained histories of the plaintiff's firing a hundred rounds at the annual pistol shooting practice, but that history is incorrect. The plaintiff told me in his sworn oral evidence that he discharged about 36 to 40 rounds during the annual pistol shooting. He also told me that after three or four years of unmasked pistol shooting practice that hearing protection was provided. That would have been at least by the commencement of the 1980 and as time has gone by the quality of the hearing protection has increased. All the ENT specialists agree that the plaintiff's service in the Australian Army Reserve is irrelevant, but minds differ as to the sources of noise being greater than the annual pistol shooting practice and exposure to siren noise. Dr Harrison diagnosed a 6.6% loss of binaural hearing, which after a deduction for presbyacusis is 5.8%.

43 The plaintiff was also sent to see Dr Robert Payten, an ENT surgeon by the defendant. Dr Payten thought the plaintiff's audiogram showed a mild to moderate high frequency sensorineural deafness, consistent with noise trauma. He thought that that caused an incapacity for work. He expressed this view:

> "His high frequency sensorineural deafness demonstrated on his audiogram indicates that he would have difficulty hearing conversations, especially in noisy background. He would therefore not be able to communicate effectively and therefore not be able to perform the functions of a police officer. He might also find it difficult to take messages effectively on the telephone, especially when talking to people with foreign accents. He would also have problems with accurately taking messages over the police radio, especially in the presence of background noise."

That appears to be a very generous assessment of the effect of a relatively low level of deafness.

44 Another opinion has been provided by Dr Brian Williams, also an ENT surgeon, qualified yet again by the defendant. Dr Williams took this history of the plaintiff's exposure to noise in the Police Force:

> "Police Force 1975-2017, 41 years, seven months and five days.

• Police motorcyclist, 1983-2015 (32 years) and sometimes in a car - 70% on the bike and 30% in a car. He said he was exposed to the noise of:

- speakers in helmet for police radio.

- wind noise

- engine noise - if the engine is revving, like he's travelling on a street or freeway (he would have to raise his voice and yell and stop the bike

or idle to have a conversation at one metre)

- sirens 3-4 times per day for 10 seconds or two minutes on escort. He said maximum time was four minutes. He said he would have to turn the siren off to have a conversation at one metre. He said the siren was located near the leg on either side.

-he said he was on the motorbike 5-8 hours per day, riding the motor cycle on the freeway and local roads of varying speed - 50% on freeway at high speed and 50% in towns. He said no hearing protection was worn.

• Pistol firing once a year (Smith & Wesson then Glock) at an outdoor range. He said there were five items, six people in a line. He said that he fired 60-80 rounds per training, plus was exposed to five to six other people firing. He said no hearing protection was worn for the first four years, then hearing protection was worn.

• Tarmac noise during escort duties once a month for 12 years. He said he was exposed to the noise of jet engines for three minutes per episode.

• He said no one episode he was washing a Police car and two siren on the roof bar activated for one second. He said he noted dulled hearing temporarily. He said he had no tinnitus and no vertigo. "

Dr Williams expressed the view the plaintiff was unable to do office work because of his hearing loss. Because of that loss he cannot hear the telephone and had difficulty communicating. The doctor also thought that the plaintiff became angry and frustrated when he was unable to hear. Dr Williams thought that the plaintiff thought that the problem was a "moderate one". Dr Williams clearly accepted an incapacity due to the boilermakers' deafness. In a supplementary report, Dr Williams expressed the view that the extent of the plaintiff's hearing loss was 5.1% binaurally, less than the assessment made by Dr Harrison.

45 Finally I have an assessment made by Dr Joseph Scoppa, an otorhinolaryngologist. Dr Scoppa was qualified by the plaintiff's solicitors. Dr

Scoppa's history of noise exposure is fuller than those made by Dr Harrison and Dr Williams, but is contentious. Dr Scoppa's outline of the plaintiff's noise exposure commences on the third page of his report of 3 October 2018. The first point he notes is of exposure to noise of police car sirens, police car radios, alarms and traffic noise. The second is of noise during crowd control duties at demonstrations and sporting events. The plaintiff gave no evidence of being exposed to noise of demonstrations or sporting events. He referred to neither of those activities in his evidence. It is unusual for Highway Patrol officers to be involved in riot control or to be attending sporting events. Furthermore, people attend sporting events for entertainment and amusement, and during the COVID-19 lockdown there was much community anguish about not being able to attend sporting events.

46 According to Dr Scoppa, the plaintiff was also exposed to noise from patrons and loud music at licensed premises. With the utmost respect to Dr Scoppa, the plaintiff was in the Highway Patrol, not the licensing branch and the plaintiff did not tell me about any exposure to noise at licensed premises nor did he ever mention in the course of his work having to attend upon a hotel or club or the like. Furthermore, hundreds of thousands of the citizens of this state attend licensed premises for their enjoyment and amusement, not to be deafened.

47 The doctor also had a history of noise exposure from the annual firearm practice, but again, with an exposure to discharge of 100 rounds, which is not the sworn evidence. He also took a history of noise attending and completing a Glock transition course, but I have held previously that that carried no risk and I will in due course refer to that case. He also had the plaintiff exposed to the noise of euthanasing injured animals such as cows, sheep and dogs. Dr Harrison also took that history, but he pointed out that is was so occasional as to be irrelevant. Furthermore the plaintiff could muffle the sound of the discharge of a firearm because this was something that he did deliberately and he could don his helmet to muffle the noise.

48 Dr Scoppa also had a history of Highway Patrol, driving cars and motorcycles, exposing him to the noise of traffic and wind noise due to wearing a motorcycle helmet. With the utmost respect to Dr Scoppa, every person who drives a

motorcycle in this State is required by law to wear a helmet. Every motorcycle helmet wearer would be exposed to wind noise. Furthermore, anybody on the road is exposed to traffic noise.

49 The final matter that the doctor has a history of is tarmac aircraft noise when performing police escort duties, but they would appear to be intermittent, and the exposure to tarmac aircraft noise would be only part of doing police escort work.

50 Dr Scoppa diagnosed a 9.7% loss of hearing. How he came to that he sets out in his report, but it is completely inconsistent with the assessments of Dr Harrison and Dr Williams. Furthermore, he had a 1% loading for "severe tinnitus". The plaintiff does not have tinnitus, let alone severe tinnitus, and certainly tinnitus is not a certified infirmity. The report of Dr Scoppa is of no utility whatever.

Overview

51 An overview of the plaintiff's incapacity can be found in the opinion of Dr Andrew Keller, who is an occupational physician qualified by the defendant, who examined the plaintiff on 16 January 2018. Dr Keller has a history which is important. It concerns what happened after 16 June 2015. It is this:

> "Mr McAlister continued in the Highway Patrol until on 16 June 2015, during DEFTAC training, he injured his cervical spine. He was unfit to work for one month. He was treated with physiotherapy. He eventually returned to work full time but remained on restricted administrative duties for the next two years.
>
> He came to be diagnosed with noise induced hearing loss in September 2015, which he attributed to firearms and motorcycle use. He now wears hearing aids on both sides since 2017.
>
> Mr McAlister ceased his full time administrative duties in November 2015, and went on sick [report]. He states that both the pain in his foot and the pain in his neck made him unfit to work even at administrative duties on a full time or part time basis. He was then medically retired on 9 February 2017."

It would appear, therefore, that after the plaintiff's neck injury he never returned either to Highway Patrol duties or general duties but was restricted to doing administrative work. Significantly, there is no history given that the plaintiff had to give up the administrative work because of hearing difficulties.

52 Dr Keller expressed the view that, without the plaintiff's hurt on duty conditions, he would think that the plaintiff could work full time in light or sedentary work. In his opinion the plaintiff had no capacity for work due to his HOD conditions. He expressed the view that the plaintiff was permanently unfit to work as a police officer and appeared to be unfit for all forms of work, even part time administrative duties, as he could not sit or stand or move or stand for more than brief periods. He clearly accepted that the plaintiff's foot injury resulted from the event of 22 July 1983 and his neck problem arose from the injury of 16 June 2015. It is because of that assessment by Dr Keller that the plaintiff was found by PSAC to be totally incapacitated for work, therefore entitling him to a base pension of 85% of the salary of his office.

Consideration

53 Because there are three certified infirmities it is necessary to consider the total impairment of the plaintiff - that is, the total disability resulting from each of the three certified infirmities. I refer to this in *Conway v SASTC* [2012] NSWDC 249; (2012) 11 DDCR 212 between [36] and [38]. Only a small part is played by the plaintiff's sensorineural deafness in his total disablement. The proximate cause of incapacity is the neck injury. After that the plaintiff never returned to full time operational work either in the Highway Patrol or general duties or in the VIP escort work, as the history obtained by Dr Keller which I quoted earlier says. The plaintiff was forced to give up even administrative work by the combined effect of his neck and foot problems, with perhaps some impact from the deafness. Again, that is referring to Dr Keller's history, but he makes no mention of the deafness, perhaps because it was outside his specialty.

54 Doing the best I can, I believe that 60% of the plaintiff's incapacity results from the neck injury, 30% of his incapacity results from the hallux injury and 10% of the incapacity results from the sensorineural deafness. There are 15 percentage points of the attributed salary of office available in an application under s 10(1A)(c) of the Act; therefore there is 9% that could be available for the neck injury, 4.5% available for the foot injury and 1.5% available for the sensorineural deafness.

55 The question for me is what abnormal risks was the plaintiff exposed to in respect of each of his certified infirmities. I have used the terminology "abnormal risks" because that was terminology adopted by Emmett JA in *SASTC v Green* [2014] NSWCA 289 at [35]. His Honour also used the term "exceptional risks". The shorthand used in the Special Statutory Compensation List is "special risk", but I am happy to use the term "abnormal risk" because that is closer to the terminology of the statute.

56 I shall first consider the neck injury because that constitutes the greater part of the plaintiff's disablement. It matters not that the plaintiff was exposed to a risk in the course of training rather than in the course of the execution of his duty: see *Green v SASTC* [2013] NSWDC 200 at [35]. That finding was not challenged in the unsuccessful appeal to the Court of Appeal. As at 16 June 2015 the plaintiff was aged 59 years and ten months. He was required to pose as an offender. He was engaged in by a young constable, a fitter man than the plaintiff, that young constable being from somewhere in one of the Blue Mountains police stations. He was tackled by a fit officer while posing as an offender, whereby he was thrown to the ground in order to be handcuffed. In doing that, the plaintiff sustained a transient head injury but, more importantly, the aggravation of pre-existing cervical spondylosis.

57 This is a risk to which the only people generally exposed are offenders, or suspected offenders, resisting arrest. This is obviously not a risk to which members of the general work force would normally be required to be exposed. It is accepted by the defendant itself that this was an "abnormal risk". Doing the best I can, the degree of the risk is towards the mid-range. The mid-range would indicate an award of 4.5% - that is, half of 9%. Doing the best I can, I allow 4% of the attributed salary of office because of this risk.

58 I turn to consideration of the plaintiff's left hallux/foot problem. This is hotly contested by the defendant, just as Mr Perrignon, who appeared for the defendant in *Green*, did in this Court and in the Court of Appeal. Mr Ower for the defendant, who was opposed to Mr Perrignon in *Green*, in this case submitted that there were many members of the general workforce who ride motorcycles in the course of their work - for example, farmhands, stockmen,

courier drivers, food delivery drivers, postmen and postwomen, and those who work in the motorcycle racing industry.

59 That is so, but raised in *Green* was the dichotomy of a police officer driving a police vehicle in the course of his or her employment who was injured in a motor vehicle accident compared to a policeman injured in a motor vehicle accident who was involved in a high speed pursuit. As I said in *Green* at [21]:

> No one would argue that a constable of police who was lawfully involved in a high speed police pursuit in a motor car and, because of some obstruction on the road, malfunction of the police vehicle or interference from the offender seeking to escape apprehension, was injured, was not exposed to a risk to which members of the general workforce would normally not be exposed. However, it is arguable that the risk of being involved in a motor vehicle accident in the course of one's employment would not carry such a risk. For example, a police constable driving a police vehicle or indeed the observer or passenger in a police vehicle could be injured when some errant motorist, who failed to keep a proper lookout, ran into the back of the police vehicle whilst it was proceeding in normal traffic. Equally, some constable of police proceeding in a normal line of traffic, in no circumstance of urgency, merely moving from one place to another, might himself be distracted, fail to keep a proper lookout, and collide with another motor car driven by a member of the general public.

In the Court of Appeal that dichotomy was adopted by Emmett JA at [33]:

> The Trustee accepts that a police officer engaged in a high-speed pursuit is required to be exposed to risks attracting s 10(1A)(c) because driving at high speed through urban areas without regard for the road rules in conditions of extreme urgency are both causative of injury and directly affect or increase the risk of injury. Further, the Trustee accepts that a police officer who arrests a violent offender is required to be exposed to relevant risks because effecting an arrest of a violent person is directly causative of injury and increases the level of risk. Finally, the Trustee accepts that an officer engaged in an urgent rescue operation in rough terrain from a dangerous height is required to be exposed to relevant risks that cause injury and affect the degree of risk.

60 I know from the detailed description of the course which the plaintiff was attending that it was a high-speed motorcycle driving course. The fact that the injury occurred during training is again irrelevant. It appears that the police motorcyclist was being trained to drive at a very high speed, at a speed generally forbidden to other motorcycle riders. It is clear also from the evidence which I have cited today that it was only after completing this course successfully that the plaintiff commenced working in the Highway Patrol as a

motorcycle rider. The course ran from Monday 18 July 1983 to Friday 12 August 1983, a period of five weeks. The course was from 7.30am to 2pm. Allowing a half hour break, that would indicate six hours per day, five days a week. That is 30 hours per week or, all told, 150 hours of training. During the course the plaintiff was required to drive an off-road vehicle on a dirt track. That was not directly to train him for high-speed motorcycle work but, rather, to improve his balance on the vehicle which he was riding and also to get him to use the throttle correctly. That was the effect of Mr McAlister's sworn evidence. The off-road trail bike, I am told, was a Honda 500 XL.

61 Motorcycle police riders generally ride a street bike, not trail bikes. It appears to me that the training here involved was unusual or special training for operating police road bikes at high speed. It appears to have been to encourage the officer to have greater control of the bike than would an ordinary motorcyclist. I accept that it contained an abnormal risk because it was specialised training, training to which only members of the Police Highway Patrol are exposed in order to conduct high-speed pursuits on police motorcycles. However, the risk was low. Of the available 4.5% of the attributed salary of office, I would allow 1%.

62 I turn now to the sensorineural deafness. Despite every argument that could be mounted by Mr Hammond remain unpersuaded that the plaintiff's exposure carried an abnormal risk of injury. Hearing protection was worn after four years on annual pistol training. The extent of the number of rounds discharged by the plaintiff was less than recorded by the ENT specialists. Clearly the hearing protection was available by the commencement of the 1980s.

63 In *Conway v SASTC* [2012] NSWDC 249; (2012) 11 DDCR 232 I commenced at [22] to discuss what was meant by the words "general workforce" in s 10(1A)(c). I then turned to consider the risk involved in exposure to loud noise in Mr Conway's case. I said this:

> 28. … I cannot disagree with the observation made by O'Toole DCJ in Goddard where her Honour continued in [53] thus:
>
> > "It seems to me that 'the general workforce' includes factory workers, panel beaters, motor body builders, boiler makers, sheet metal workers, construction workers, operators of power

> tools and of heavy plant and equipment on urban building sites, couriers who ride bicycles and motorcycles in congested urban traffic and local council workers who repair urban roads and footpaths: those members of the 'general workforce' are exposed [to] noise which exceeds 85 decibels. It seems to me 'the general workforce' also includes miners, abattoir workers and construction workers who use explosive and concussive devices which generate noise that is similar to small arms fire in confined spaces."

29. I wholly accept that many members of the general workforce are exposed to loud industrial noise. Indeed, in the course of argument I pointed out that making such a submission is largely otiose in light of the fact that what is now often called industrial deafness was known originally as "boilermaker's deafness" and was described in the Workers Compensation legislation as 'boilermaker's deafness' and any deafness of like origin. However, the amount of industrially caused deafness has, due to legislation commencing in the 1980s, fallen away dramatically because of occupational health and safety concerns and, for example, improved hearing protection, which is proven in the evidence of the plaintiff himself and, for example, recorded by the history he gave to Dr Payten of improvements in hearing protection.

30. It is significant, in my view, that at the time when the number of persons affected by industrial deafness was decreasing and that there were Occupational Health and Safety laws requiring employers to reduce the amount of noise generated within the workplace the plaintiff continued in his work as a weapons trainer to be exposed to the loud noise of the discharge of firearms.

31. The leading authority as to the meaning to be attributed to s 10(1A)(c) is still Thoms v SASTC, which I cite in [24] of Walsh v SASTC. It is worth repeating:

> "There are many, many risks to which policemen are required to be exposed, and which are more numerous and more dangerous than risk to which the general workforce are normally exposed. Mr Mansfield [Counsel for the respondent] identified some of them. He said, for example, that policemen are required to rescue children, babies from houses that are on fire; that they do this and the community is grateful. They are also required to arrest dangerous criminals.
>
> It seems to me that [s 10(1A)(c)(ii)] invites me to place on a spectrum various risks to which policeman are exposed and which will be uncommon, or be a risk to which the workforce would normally not be exposed, and to assess where those risks are on the spectrum, in order to make an award of a percentage of attributed salary between 85 and 100 per cent."

32. Very few people work in our community as weapons trainers. Very few people would have worked for the length of time that the current plaintiff worked with firearms and handguns. Very few people would

have been exposed to the risk of noise by being exposed to over one million rounds of ammunition fired from Smith and Wesson revolvers and Glock pistols.

33. However, here the thing which I think is pertinent is the work that the plaintiff did, in particular, training in the TRG that required him to be exposed to the noise of firearms deliberately without any form of hearing protection which, in general, would be counter to the industrial environment in nearly every industry governed by statute in this State.

34. For reasons that I will in due course come to, it was submitted to me by Mr Ower for the defendant that only "part of a part" of the 15% available could be attributed, if at all, to the plaintiff's exposure to noise which carried a risk that member of the general workforce would not normally be exposed to. That is because of the large number of certified infirmities, only some of which are the subject of the current application.

35. There is much force in what Mr Ower submitted and it is supported by authority. During the course of the same argument, I suggested to Mr Ower perhaps 1% to which Mr Ower replied "or less". Bearing in mind that part only of the plaintiff's exposure to noise carries a special or unusual or uncommon risk, to use terminology used in other judgments, I would allow half a percent for the special risk involved in the plaintiff's exposure to loud industrial noise when working in the TRG.

The issue was also discussed by me in *Green v SASTC*:

27. Similarly, one can approach my decision in *Tanks v SAS Trustee Corporation* (NSWDC RJ894/03 Neilson DCJ, 1 September 2004, unreported). The cases are legion, in which it is pointed out that members of the general workforce are often required to be exposed to loud noise such as to induce industrial deafness, formerly known as boilermaker's deafness. Indeed, the issue is discussed in *Conway v SAS Trustee Corporation* at [29] to [33]. In *Tanks*, the plaintiff's certified infirmities were caused by his having been exposed to the noise of two quick explosions at about 8.30 pm on the evening of 24 April 1993. The plaintiff, at that time, was the coordinator of the Transit Police at Lidcombe. He had held that position since January 1990. Commencing at [10], I set out the circumstances in which the plaintiff was exposed to these two quick explosions. Essentially, they were the explosions of detonators placed on a railway line. The detonators were commonly used to advise gangs of railway workers, in particular fettlers, of the approach of oncoming trains. Commencing at [12], I said this:

> "12. On 25 October 1995 the plaintiff made a statement about the events of the evening of 24 April 1993. Paragraphs 10, 11 and 12 of that statement recite what occurred and I shall recite them in these reasons for judgment:
>
> 'We had climbed down onto track level and commenced to walk in different directions along the Bankstown line on the southern side of the tracks. Vince went easterly direction and I went in a westerly direction. I was in the vicinity of the last staunchion for

> overhead wiring and approaching the overhead bridge, when I heard a train approaching from the Birrong direction. I moved back towards the embankment for safety reasons, which is approximately one to one and a half metres south of the southernmost railway line.
>
> The train approached [sic] at a moderate speed and when the driver's compartment at the front of the train came directly along side of me I heard two quick explosions, which immediately caused [sic] me to go deaf in both ears.
>
> The train appeared to slow and then continued past me. As I could not hear I stood there for what appeared a short time before commencing to walk towards Collucio who at that time I think was walking in my direction. I was still suffering deafness, before a loud ringing in my ears. After about what appeared to me to be one to two minutes of complete deafness, my hearing started to come back at more or less the same time as the ringing took over. I cannot recall the exact conversation between Collucio and myself about this incident, but it was to the general effect of Vince checking to see if I was O.K. first, and then a general discussion, although I didn't see them, that the explosion was that of railway detonators. Due to being certain of the explosion being that of railway detonators, and the loud ringing in my ears, we return [sic] to the police vehicle without further inspection in that area.'
>
> 13. There in evidence photocopies of four photographs. The photocopies are not of good quality, however I infer from the photograph numbered 3, and from the general experience of any person who has ever ridden on the railways of Sydney that the area between the railway line and this embankment would be at a lower level than the railway line itself. Railway detonators had been placed on the line with a view to their exploding, the noise being, in theory, designed to warn both the train driver and the workmen working on the line, that, firstly, there were workmen on the line and, secondly, that the train was approaching. The inference I draw is that the plaintiff was standing beside the embankment probably with his feet at a lower level than the level of the railway line itself, that is the steel line, between one and a half metres from the railway line, and would have had his ears much closer to the detonators than, for example, the driver of the train or any passenger in the train."

In the next paragraph of my reasons, I quoted the subsection and continued thus:

> "15. The first question for my determination is whether the plaintiff was exposed to a risk to which members of the general workforce would normally not be required to be exposed in the course of their employment. No doubt there are many members of the normal workforce who, with reckless indifference to

> punctuality, travel daily to and from work on railway trains. There are many railway commuters who have heard the noise of these detonators placed on railway lines. Equally, there would be many train drivers and train guards who have heard the noise of railway detonators and there were many fettlers and other railway personnel who would hear the noise of railway detonators. However the crew and the passengers in a railway train would be insulated from the noise of the detonation by the physical fact that they were above the detonation and by the steel undercarriage of the railway line and the steel and glass fabric of the railway cars. The railway cars themselves would insulate crew and passengers from the extent of the detonation. Equally, in the normal course of the operation of the railways those working on the line would be at some distance from the site of the detonation. The evidence does not disclose how far the detonators are placed from those working on the railway line, but one would think in the exercise of commonsense that it would be some distance, perhaps hundreds of metres, in order that those working on the line, alerted of the oncoming train by the noise of the explosion, would have time to remove themselves and any tools or equipment with which they were working from the line in order to enable the train to pass the area where they were working.
>
> 16. The plaintiff was placed in a position which no ordinary member of the workforce would normally be placed, that is, within one to one and a half metres of the site of the detonation, without any protection of his hearing, without any barrier to muffle the sound, and at a level where the sound of the detonation would be closer to his ears than it would be to any other person. Equally, the evidence in this case, and it is commonsense, indicate that members of the general public are not permitted on the railway reservation, that the only people who can be on a railway reservation at any time outside of being within a train, are railway personnel and members of the emergency services, and it is conceded by learned counsel for the defendant [Mr Ower] that the only person or persons who would possibly be patrolling railway lines at night would be members of the New South Wales police force."

28. In *Tanks'* case, the question was not the risk of being exposed to loud noise nor the risk of being exposed to the noise of railway detonators, but to the risk of being exposed to the noise of railway detonators at very close quarters without hearing protection and unexpectedly.

64 Many members of the workforce are exposed to the noise of sirens. They include police officers, ambulance officers, fire and rescue service workers, members of bushfire brigades, members of the SES, other road users, and workers on the road who must listen to this constantly.

65 It is compulsory to wear motorcycle helmets in this State. They are worn, clearly, by police motorcycle riders. Wind noise is common to every motorcycle rider. Every motorcycle rider is exposed to the noise of motorcycle engines and other road noise. I have already quoted Dr Patterson's observation that the police radio within a police motorcycle rider's helmet would be unlikely to be adjusted at such a level as to cause loud noises. However, many motorcycle riders ride and listen to music or the radio within their bike-riding helmets. The only difference is that the police motorcyclist would take less pleasure in listening to broadcasts on VKG than his own recorded music or the radio.

66 When called upon to euthanase an injured animal, which was very rare, the plaintiff, as I have already mentioned, could have reduced the level of noise by wearing his helmet when he discharged his firearm. As I have already mentioned, the noise of patrons at hotels and clubs or at music festivals or in demonstrations and the like are noises to which many members of the general work force are exposed. Indeed, many people expose themselves to such loud noises for pleasure. I am not persuaded that the plaintiff's police work exposed him to any abnormal risks which were injurious to his health.

67 Those who have succeeded in such a finding have to show something more, as was the case in *Conway* and as was the case in *Tanks*, which I cited in *Green*.

68 I trust that the reasons I have given thus far are sufficient to dispose with this application. Clearly, on my findings the plaintiff is entitled to an increase in his pension of 5% above 85%. That is, he is entitled to a pension of 90% of the attributed salary of his office.

69 Does anyone want any further reasons?

CABAL: No, your Honour.

DOYLE: Not further reasons, your Honour.

70 HIS HONOUR: I have inquired of the solicitors for the parties if any further reasons for judgment are required. I am told that none is so required. For those reasons I set aside the decision of the Police Superannuation Advisory Committee made on behalf of the defendant on 30 May 2019. I determine that

the plaintiff's pension be increased to 90% of the attributed salary of his office by reason of the fact that he was exposed to risk to which members of the general work force would not normally be required to be exposed in the course of their employment. That pension increase will commence on 10 February 2017. I order the defendant pay the plaintiff's costs.

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