[2014] AATA 262

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| Division | **Veterans' Appeals Division** |
| File Number(s) | 2011/3352 |
| Re |  |
|  | APPLICANT |
| And | Military Rehabilitation and Compensation Commission |
|  | RESPONDENT |

# Decision

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| Tribunal | **Senior Member Bernard J McCabe** |
| Date | **2 May 2014** |
| Place | **Brisbane** |

The decision under review is affirmed.

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**Senior Member Bernard J McCabe**

**Catchwords**

VETERANS’ AND MILITARY COMPENSATION – Application for compensation for “service death” – Soldier suffered fatal heart attack – Applicant relied on Statement of Principles concerning ischaemic heart disease and Statement of Principles concerning hypertension – Conditions of hypertension and dyslipidaemia not linked to service –No assessment of inability to perform physical activity to required level – Soldier’s ischaemic heart disease not linked to service – Reviewable decision affirmed.

**Legislation**

Military Rehabilitation and Compensation Act 2004 (Cth) ss 7; 28

Military Rehabilitation and Compensation (Consequential and Transitional Provisions)   
Act 2004 (Cth) s 7

Safety, Rehabilitation and Compensation Act 1988 (Cth)

Statement of Principles concerning ischaemic heart disease No. 90 of 2007

Statement of Principles concerning hypertension No. 64 of 2013

**Cases**

Roncevich v Repatriation Commission (2005) 222 CLR 115

# REASONS FOR DECISION

**Senior Member Bernard J McCabe**

**2 May 2014**

1. Mr Gregory Riley was a full-time member of the Army Reserve when he suffered a fatal heart attack at work on 27 February 2007. His widow, Mrs Kerri Riley, has applied for compensation under the *Military Rehabilitation and Compensation Act 2004* (Cth)   
   (“the MRC Act”). Mrs Riley argues the Commonwealth is liable for her husband’s death because it was a “service death” within the meaning of s 28 of the MRC Act – which means, relevantly, it “arose out of, or was attributable to, any defence service rendered by the person while a member”: s 28(1)(b).
2. There is no dispute Mr Riley’s heart attack was the product of coronary artery disease.   
   It follows the kind of death he suffered was *ischaemic heart disease*. The medical evidence established the date of onset of that condition was 27 February 2007. I must have regard to the Statement of Principles (“SoP”) concerning ischaemic heart disease (No 90 of 2007) to resolve the question over any link between that condition and   
   Mr Riley’s service.
3. As I will explain, the outcome of this case ultimately turns on a factual enquiry into:

* the quantity and circumstances of Mr Riley’s alcohol consumption; and
* his ability to undertake physical activity.

1. The applicant’s claim cannot succeed. I explain my reasons below.

# the statementS of principles

1. The SoP concerning ischaemic heart disease identifies a number of factors which *might* establish a link to service. An applicant need only identify one that is relevant. In this case, the applicant relies on any one of three factors that might be available:

* The late veteran experienced hypertension (high blood pressure) before the clinical onset of ischaemic heart disease (factor 6(a));
* The late veteran had dyslipidaemia (a disorder of the blood fats) before the clinical onset of ischaemic heart disease (factor 6(f)); or
* The late veteran was unable to undertake any physical activity greater than three METs[[1]](#footnote-1) for at least the seven years before the clinical onset of ischaemic heart disease (factor 6(j)).

1. Mr Riley was being treated for hypertension and experienced dyslipidaemia in advance of the onset of ischaemic heart disease. But that does not mean the claim succeeds without more. I must still be satisfied there is a link between *those* conditions and   
   Mr Riley’s service. I will deal firstly with the argument in respect of hypertension.

## Was Mr Riley’s hypertension condition related to his service?

1. In order to establish a link between service and the hypertension condition, I must consult the Statement of Principles concerning hypertension (currently no 64 of 2013). But the Commission says the applicant must first clear a hurdle that arises out of the timing of the introduction of the MRC Act. Mr Dube, who appeared for the Commission, noted   
   s 7(1) of the *Military Rehabilitation and Compensation (Consequential and Transitional Provisions) Act 2004* (Cth) says the MRC Act only applies to injuries sustained and diseases contracted on or after the commencement of the MRC Act on 1 July 2004.   
   Mr Dube says that is a problem for the applicant as Mr Riley’s hypertension condition appears to pre-date the commencement date. If that is right, any claim in respect of that condition (or a death that resulted from it) would have to be brought under the   
   *Safety, Rehabilitation and Compensation Act 1988* (Cth) (“the SRC Act”).
2. The latest iteration of the SoP concerning hypertension is no 64 of 2013. There are no relevant differences between that SoP and earlier iterations. Clause 3(b) defines hypertension as “persistently elevated blood pressure” diagnosed by a medical practitioner and evidenced by (i) blood pressure readings within a particular range; or   
   (ii) “the regular administration of antihypertensive therapy to reduce blood pressure”.
3. The medical records clearly establish Mr Riley was diagnosed with hypertension on   
   23 March 2004: see Exhibit A at p 295. His doctor prescribed Propranolol, a hypertensive medication, on that date: see Exhibit A at p 281. When Mr Riley was seen for the purposes of a review on 6 July 2004, the clinical notes record he was “now on” a daily 40mg dose of the medication: see Exhibit A at p 269.
4. Mr Black, for the applicant, said I should construe the SoP concerning hypertension generously given the beneficial nature of the legislation. Unfortunately for the applicant, the words of the SoP do not suggest any ambiguity that can be resolved in her favour.   
   Mr Riley was diagnosed in March 2004 and was prescribed hypertensive medication at that point. While it is possible it took time for Mr Riley to settle into an established pattern of using the prescribed drugs, the clinical notes made in connection with his review soon after the beginning of July clearly indicate he was already being medicated at that point. Given that review was conducted only a matter of days after the commencement of the MRC Act, I am satisfied Mr Riley was already experiencing hypertension within the meaning of the SoP before the commencement of the legislation – which means his claim in respect of this condition would have to be made under the SRC Act rather than the MRC Act. It follows Mr Riley’s ischaemic heart disease cannot be related to his service under the MRC Act by reason of hypertension.

## Can Mr Riley’s ischaemic heart disease be linked to his service in another way?

1. I have already noted Mrs Riley says her late husband’s condition could be linked to his service by reason of his dyslipidaemia and his inability to undertake the requisite level of physical activity. Dyslipidaemia is defined in clause [9] of the SoP concerning ischaemic heart disease as “persistently abnormal lipid” [i.e. cholesterol and triglyceride] levels. There is no doubt Mr Riley met this requirement – but why? If the cause can be related back to his service, the necessary link between his service and his death might be established.
2. I was provided with evidence of Mr Riley’s drinking habits. Excessive alcohol intake is known to increase the risk of dyslipidaemia. Mrs Riley said she recalled her husband consuming at least two four-litre casks of wine each week in the years before his death. She said he also routinely consumed spirits each evening. But that all happened at home, after hours. I need more if I am to connect that drinking habit with his work.
3. Mr Anthony Cotroneo gave evidence at the hearing and provided a statement.   
   Mr Cotroneo was an Army officer. He supervised Mr Riley and knew him well.   
   Mr Cotroneo spoke highly of Mr Riley and said he was a capable and well-regarded soldier. But Mr Cotroneo also said he was aware Mr Riley drank and smoked excessively.
4. Mr Cotroneo gave valuable evidence about the consumption of alcohol on the Army base at Oakey where Mr Riley was posted. Mr Cotroneo pointed out in his oral evidence that the mess did not commence serving alcohol until 4pm each day, although it remained open until late in the evening. Soldiers did not have the opportunity to drink during the day in the ordinary course. (That had not always been the case, he explained from the witness box: in the past, the mess served alcohol during the day.) He agreed there was an expectation that soldiers like Mr Riley would attend a formal mess once each quarter when alcohol was served. There was also an informal expectation one would visit the mess at least once a day – either for morning tea or lunch when alcohol was not served, or in the afternoon – and for “happy hour” in the evening on payday each fortnight.   
   He went on to say the culture of heavy drinking that pervaded the military in earlier years had faded with the introduction of random breath testing and tougher drink-driving laws.
5. The applicant referred me to the decision of the High Court in *Roncevich v Repatriation Commission* (2005) 222 CLR 115. In that case, a soldier was injured when he fell out of a window while intoxicated. He became intoxicated while attending a formal mess earlier that evening. The evidence established it was expected that soldiers like Mr Roncevich would attend the mess, and that they would imbibe. Soldiers would inevitably come into contact with (and effectively participate in) a strong culture of heavy drinking in the course of undertaking activities that were expected of them in their work. The Court was satisfied the injury that was a consequence of Mr Roncevich’s intoxication “arose out of” the soldier’s service: at 125-126 per McHugh, Gummow, Callinan and Heydon JJ.
6. The causal connection between work and injury was easy enough to establish in *Roncevich* because the accident in question occurred while the soldier was still drunk as a result of the work event. But the facts are different in this case. Mr Riley did not sustain an injury while drunk. The applicant asserts her late husband developed dyslipidaemia over time because of persistent heavy alcohol intake. In order to succeed, I must be satisfied Mr Riley was effectively habituated to alcohol as a consequence of his work.   
   I do not think the evidence goes that far.
7. Mr Riley was expected to attend the mess each day, but it did not serve alcohol until the afternoon when he finished work. He was expected to attend after work at least once a fortnight, and he also attended a formal mess once each quarter. The formal messes were not of sufficient frequency to promote habituation; even the fortnightly visits to the mess that were expected on payday were unlikely to have had that effect. (I was not provided with any expert evidence to suggest infrequent visits to the mess would lead to habituation.) Importantly, Mr Cotroneo explained the heavy drinking culture – a culture that might have pervaded military establishments in the past and sucked in soldiers like Mr Riley – had faded, at least amongst the soldiers who lived off-base. I am not satisfied Mr Riley became a heavy drinker for cultural reasons associated with his work.
8. There was also evidence to the effect that Mr Riley drank heavily to cope with stress associated with his work. It is difficult to know what to make of this. I accept   
   Mrs Riley’s evidence (and that given by her daughter, Ms Mason) that Mr Riley was working long hours before his death, and that he was under pressure at work. But the evidence also appears to establish his drinking persisted over a long period. It is difficult to be sure of the genesis of that habit. I am not satisfied that aspect of the claim has been made out.

## Was Mr Riley’s ischaemic heart disease linked to an inability to undertake physical activity?

1. I turn to the claim Mr Riley was unable to undertake physical activity at the requisite level. The claim is relevant in two ways: firstly, because individuals who exercise regularly are likely to have lower levels of lipids (so that a failure to undertake regular physical activity is a factor in developing dyslipidaemia), and secondly, because an inability to exercise is a factor in the development of ischaemic heart disease.
2. The respondent relies in particular on evidence showing Mr Riley passed the Defence Department’s Basic Fitness Assessment (BFA) on a number of occasions in the relevant period before his death. Mr Dube argued I could not be satisfied Mr Riley was unable to engage in physical activity if he was able to pass a relatively demanding fitness test (albeit one that was not as demanding as the Combat Fitness Assessment, or CFA, which soldiers on the front line were required to pass). Mr Dube also pointed to the evidence of Mr Cotroneo, who supervised physical training activities and conducted informal BFAs for his unit. Mr Cotroneo recalled Mr Riley – along with other soldiers in the unit – attended personal training sessions three times a week. He also recalled at least two occasions on which he watched Mr Riley running or walking in the course of an informal BFA. (Mr Billens, a witness called by the applicant, confirmed Mr Riley participated in a run or walk as part of an informal BFA. Mr Billens recalled running with Mr Riley, who was towards the back of the group, in order to provide encouragement.)
3. Mr Cotroneo confirmed Mr Riley was subject to medical restrictions as a result of long standing service-related injuries. The applicant said these injuries made it impossible for him to exercise at the requisite level of intensity. Mr Cotroneo agreed soldiers in   
   Mr Riley’s position would participate in a modified program that was designed to accommodate their restrictions. He also agreed a soldier would pass the BFA provided he or she did whatever was required of him or her in light of those restrictions. Mr Black, for the applicant, pointed out it was impossible to be sure Mr Riley had actually completed a program that satisfied the minimum requirements in the SoP. In particular, Mr Black said it was impossible to be sure Mr Riley had completed a run or even a walk of the required duration and intensity.
4. Dr Hossack, a cardiologist, said in his supplementary report of 30 July 2013 (Exhibit K) that he had reviewed the Department of Defence expectations of a BFA for a 42 year-old male in 2001 and 2004 (Exhibit M at p 7). He also reviewed Mr Riley’s BFA results showing he had obtained a ‘Pass’ or ‘Med Restricted Pass’ for BFAs attempted during the period from 27 February 2000 to 27 February 2007. Based on this material,   
   Dr Hossack concluded Mr Riley “had the ability to undertake physical activity greater than 3 METS in the seven years before the clinical onset of ischaemic heart disease”.   
   Dr Hossack agreed during oral evidence he was unsure of what assessment to make if the evidence established Mr Riley had merely done push-ups or other activities without running or walking. Dr Hossack added that Mr Riley’s dyslipidaemia was suggestive of someone who did not regularly exercise (although that is not the test, of course: the test refers to an *inability* to undertake activity, not a *failure* to undertake the activity regularly).
5. While it is difficult to be sure of precisely what Mr Riley did by way of physical activity, or how often he did it, I am satisfied the evidence of Messrs Cotroneo and Billens confirms Mr Riley was able to complete a BFA incorporating a walk, if not a run, at a level suggesting he was capable of undertaking activity that met the three METs standard on at least one occasion in the period before his death. Both Messrs Cotroneo and Billens confirmed Mr Riley was not very fit or athletic, and both noted he had difficulty meeting the required standard – but Mr Cotroneo noted Mr Riley was not the slowest or most unfit soldier, and that he did not perform so poorly that he was required to do remedial work to meet the BFA.
6. I accept Mr Riley experienced some impairment as a consequence of his work-related injuries. Those injuries necessitated medical restrictions on his ability to exercise.   
   They undoubtedly made exercise more difficult and less attractive, and he may have exercised much less as a result – which may have contributed to the elevated lipid levels and the onset of dyslipidaemia. But I am satisfied the evidence establishes Mr Riley was able to undertake physical activity at the required level, even if it is doubtful he did it very often. It follows that his ischaemic heart disease cannot be attributed (directly or indirectly) to an inability to undertake physical activity.

# conclusion

1. The decision under review must be affirmed for the reasons given.

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| I certify that the preceding 25 (twenty-five) paragraphs are a true copy of the reasons for the decision herein of Senior Member Bernard J McCabe |

......................Sgd............................

Dated

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| Dates of hearing | **7 & 8 April 2014** |
| Counsel for the Applicant | **Mr M Black** |
| Solicitors for the Applicant | **KCI Lawyers** |
| Solicitors for the Respondent | **Mr B Dube**  **Sparke Helmore Lawyers** |
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1. A MET is a unit of measurement of physical exertion. [↑](#footnote-ref-1)