Smith; Secretary, Department of Social Services and (Social services second review) [2015] AATA 578(14 July 2015)

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| --- | --- |
| Division | **General Division** |
| File Number | 2014/2420 |
| Re |  |
|  | APPLICANT |
| And |  |
|  | RESPONDENT |

# Decision

|  |  |
| --- | --- |
| Tribunal | **Deputy President K Bean** |
| Date | **14 July 2015** |
| Date of written reasons | **10 August 2015** |
| Place | **Adelaide** |

The decision under review is:

* 1. varied so as to provide that Mr Smith satisfied the qualification requirements for disability support pension contained in subss 94(1)(a), (b) and (c) of the *Social Security Act 1991* only from 10 September 2013; and
	2. otherwise affirmed.

............. [Sgd] ..........................................

**Deputy President K Bean**

# Catchwords

SOCIAL SECURITY – Disability support pension – Whether respondent’s heart condition fully diagnosed, treated and stabilised during assessment period – Whether impairments attract a rating of 20 points or more under the Impairment Tables – Whether continuing inability to work – Decision under review affirmed.

# Legislation

Social Security Act 1991, s 94

Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011

# Cases

Re Bobera and Secretary, Department of Families, Housing, Community Services and Indigenous Affairs [2012] AATA 922

Re Fanning and Secretary, Department of Social Services (2014) 144 ALD 133

The Hospital Benefit Fund of Western Australia Inc v Minister for Health, Housing and Community Services (1992) 39 FCR 225

# REASONS FOR DECISION

**Deputy President K Bean**

**10 August 2015**

1. On 17 June 2013, the respondent, Mr Smith, lodged a claim for disability support pension (DSP). That claim was rejected both at first instance and upon review by a Centrelink Authorised Review Officer. Mr Smith subsequently sought review by the Social Security Appeals Tribunal (SSAT) and on 11 April 2014, the SSAT decided that, subject to all other requirements being met, he was eligible to receive DSP from the date of his claim as he satisfied the provisions of subs 94(1) of the *Social Security Act 1991* (the Act).
2. However, on 12 May 2014, the applicant, the Secretary of the Department of Social Services (the Secretary), lodged an application with this Tribunal for review of the SSAT’s decision, giving rise to these proceedings.
3. Following the hearing on 6 July 2015, I delivered my decision and reasons orally on 14 July 2015. On 16 July 2015, a request was made on behalf of the Secretary for written reasons, and these Reasons have been prepared in response to that request.

# LEGISLATION AND ISSUES

1. In broad terms the issue before me is whether Mr Smith was qualified for DSP as at the date of his claim on 17 June 2013 or within 13 weeks of that date (the assessment period).[[1]](#footnote-1) As I will discuss further later in my Reasons, having regard to the statutory context, the Tribunal is required to address the issue of qualification strictly by reference to the assessment period and the facts as they were during the assessment period.
2. Qualification for DSP is governed by s 94 of the Act, which, at the relevant time, relevantly provided as follows:
3. **Qualification for disability support pension**
4. A person is qualified for disability support pension if:
	1. the person has a physical, intellectual or psychiatric impairment; and
	2. the person’s impairment is of 20 points or more under the Impairment Tables; and
	3. one of the following applies:
		1. the person has a continuing inability to work;

…

Continuing inability to work

(2) A person has a **continuing inability to work** because of an impairment if the Secretary is satisfied that:

(aa) in a case where the person’s impairment is not a severe impairment within the meaning of subsection (3B)—the person has actively participated in a program of support within the meaning of subsection (3C); and

(a) in all cases—the impairment is of itself sufficient to prevent the person from doing any work independently of a program of support within the next 2 years; and

(b) in all cases—either:

 (i) the impairment is of itself sufficient to prevent the person from undertaking a training activity during the next 2 years; or

(ii) if the impairment does not prevent the person from undertaking a training activity—such activity is unlikely (because of the impairment) to enable the person to do any work independently of a program of support within the next 2 years.

 Note: For **work** see subsection (5).

(3) In deciding whether or not a person has a **continuing inability to work** because of an impairment, the Secretary is not to have regard to:

 (a) the availability to the person of a training activity; or

(b) the availability to the person of work in the person’s locally accessible labour market.

…

**work** means work:

(a) that is for at least 15 hours per week on wages that are at or above the relevant minimum wage; and

(b) that exists in Australia, even if not within the person’s locally accessible labour market.

...

# Did MR SMITH HAVE A PHYSICAL, INTELLECTUAL OR PSYCHIATRIC IMPAIRMENT?

1. The Secretary does not dispute that, during the assessment period, Mr Smith suffered from physical impairments, namely chronic neck and back pain and a heart condition, and therefore satisfied subs 94(1)(a) of the Act.

# At the relevant time, did Mr Smith have an impairment attracting 20 or more points under the impairment tables?

1. As set out above, subs 94(1)(b) of the Act requires that a person have 20 or more points under the Impairment Tables. The *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011* (the Determination) contains rules for applying the Impairment Tables, as well as the Impairment Tables themselves.
2. The Determination outlines the requirements that must be satisfied before an impairment rating can be assigned for a condition. These include:
* the condition causing the impairment is permanent; and
* the impairment resulting from the permanent condition is more likely than not to persist for more than two years.
1. Further, for a condition to be considered permanent under the Determination:
* the condition must be fully diagnosed by an appropriately qualified medical practitioner;
* the condition must be fully treated and fully stabilised; and
* the condition must be more likely than not to persist for more than two years.
1. Subsection 6(5) of the Determination also provides that, in determining whether a condition is fully diagnosed and fully treated, the following is to be considered:
* whether there is corroborating evidence of the condition;
* what treatment or rehabilitation has occurred in relation to the condition; and
* whether treatment is continuing or planned in the next two years.
1. Subsection 6(6) provides that a condition is fully stabilised if:
* the person has undertaken reasonable treatment for the condition, and it is considered that any further reasonable treatment is unlikely to result in significant functional improvement to a level enabling the person to undertake work in the next two years; or
* the person has not undertaken reasonable treatment, but such treatment is not expected to result in significant functional improvement to a level enabling the person to undertake work in the next two years; or
* the person has not undertaken reasonable treatment, and there is a medical or other compelling reason for the person not to undertake such treatment.

## Chronic Neck and Back Pain

1. There is no dispute in this matter that as at the assessment period Mr Smith’s neck/back condition had been fully diagnosed, treated and stabilised and attracted 10 points under Table 4 of the Impairment Tables, and I regard the Secretary’s concession to that effect as having been properly made on the evidence before me.

## Heart Condition

### Was the condition fully diagnosed, treated and stabilised?

1. The Secretary contends that Mr Smith’s heart condition was not fully diagnosed, treated and stabilised during the assessment period from 17 June 2013 to 16 September 2013.
2. In relation to this issue, Mr Dubé, who appeared as counsel for the Secretary, drew my attention to the Tribunal’s decision in *Re Bobera and Secretary, Department of Families, Housing, Community Services and Indigenous Affairs* where the Tribunal observed:

In the Tribunal’s consideration as to whether a condition has been stabilised and is likely to persist for the foreseeable future, the Tribunal must look at the situation as it was, and the evidence that was available, at the time of the application for DSP (and the subsequent 13 weeks). Any subsequent evolution of a particular condition might be relevant to any weight the Tribunal places on competing prognostications or on an assessment of the quality of the medical reports provided (most notably where evidence indicates that the creator of a medical report may not have had access to all relevant information or may not have turned his or her mind to all the relevant issues).This point is important as it is quite frequently the case that appeals on DSP decisions arrive at this Tribunal twelve or more months after the initial DSP application was refused. In many instances, the natural course of illnesses or injuries has then become more obvious, thereby confounding the professional opinions honestly proffered by thorough and conscientious treating doctors. If a medical condition has progressed since the time of the original DSP application, then it is up to the applicant to make a new DSP application. It is not open in law for this Tribunal to use any evidence of such progression to directly award a DSP because of those changed circumstances.[[2]](#footnote-2)

1. I also note the following observations of Deputy President Handley in *Re* *Fanning and Secretary, Department of Social Services*:

31. In my view, in the case of DSP, it is implicit in cl 4 of Sch 2 of the Administration Act that an applicant must be qualified for DSP on the date of claim or with the period of 13 weeks following. Evidence, such as medical reports, that come into being after the relevant period may still be relevant, but only in so far as they are referrable to the applicant’s condition during the relevant period.

32. This is supported by the judgment of Gyles J in Harris v Secretary, Department of Employment and Workplace Relations (2007) 158 FCR 252; [2007] FCA 404. Gyles J stated at [1] that as an applicant’s entitlement to DSP must be considered at the date of claim and within the 13 week period, “Any subsequent change in her health is irrelevant to the questions which arise in this proceeding except in so far as it may cast light on the position at the relevant time”.

33. The language in cl 6(5) and (6) of the 2011 Determination is forward-looking. With respect to whether a condition was fully stabilised, for example, the question for the tribunal is whether “any further reasonable treatment is unlikely to result in significant functional improvement to a level enabling the person to undertake work in the next 2 years” (emphasis added). While hindsight may suggest that treatment did not result in improvement within 2 years, that is not the question for the tribunal to determine. The legislation requires the tribunal to consider the treatment that has taken place, **and was intended to take place**, and the likely effect of that treatment, at the time of the claim and in the 13 weeks thereafter. For that reason, evidence of treatment, and the efficacy of that treatment, after the relevant period is not directly relevant to the tribunal’s decision.[[3]](#footnote-3) (emphasis added).

1. Significantly, I also note that Deputy President Handley’s observations are consistent with the decision of the Full Federal Court in *The Hospital Benefit Fund of Western Australia Inc v Minister for Health, Housing and Community Services* (1992) 39 FCR 225. That matter involved review of a decision of the Minister that the imposition by a registered health insurance organisation of a five-year waiting period before certain hospital benefits could be obtained by a contributor in respect of IVF treatment[[4]](#footnote-4) imposed an *“unreasonable or inequitable condition affecting the rights of … contributors”*. At p 234, the Court said:

The second separate criticism of the Tribunal's approach which was made by the applicant concerns the admission of evidence relating to developments in IVF techniques, and their consequential costs reductions, after 1 July 1989. The applicant argues that the question for the Minister, in exercising power under s 78(4)(b), is whether the change “imposes” an unreasonable or inequitable condition affecting the rights of any contributors. The use of the present tense, it is said, emphasises the point that the Minister is concerned with the effect of the change as at the date when it is made; or, perhaps, when it takes effect. It is inconsistent with that situation, the applicant says, for the Minister's decision to be set aside by reference to events which occurred after that day. If later events could be taken into account, a change which did not impose an unreasonable or inequitable condition when made would be liable to be set aside because later events made it appear unreasonable or inequitable.

We think that this argument is sound. It is, of course, well established that the Tribunal determines what was the correct or preferable decision having regard to the whole of the evidence placed before it. It is not confined to the evidence which was before the primary decision-maker. The Tribunal is, however, obliged to address the same question as was before the primary decision-maker. This distinction was spelled out by Davies J in [Freeman v Secretary, Department of Social Security](http://www.westlaw.com.au/maf/wlau/app/document?&src=rl&docguid=I4d35eef39cec11e0a619d462427863b2&hitguid=Id75fdd119cc111e0a619d462427863b2&snippets=true&startChunk=1&endChunk=1) [(1988) 19 FCR 342](http://www.westlaw.com.au/maf/wlau/app/document?&src=rl&docguid=I4d35eef99cec11e0a619d462427863b2&hitguid=Id75fdd0e9cc111e0a619d462427863b2&snippets=true&startChunk=1&endChunk=1).

In the present case, the question before the primary decision-maker (the delegate of the Minister) was whether, at the time it took effect, the change imposed an unreasonable or inequitable condition; not whether, in the light of developments over the ensuing three years until the Tribunal hearing, the effect of the rule change was to occasion a state of unreasonableness and inequity to contributors. Of course, in considering the position as at the date of the rule change, the Tribunal is not confined to the historical position. It is entitled to receive evidence as to prospective developments in relation to IVF, as they appear at the date of the rule change. The reason is that, in evaluating the effect of the change as at that date, account may be taken of predictable developments. But the evidence must be related back to the date of the change.

It is apparent that, in the present case, the Tribunal not only received a considerable body of evidence concerning IVF developments after 1 July 1989, not shown to have then been predictable; it was influenced by that evidence in reaching its ultimate conclusion. This was a further error of law requiring the setting aside of the Tribunal's decision.

1. It is therefore clear from the authorities that in addressing the question of whether a claimant is qualified for DSP during the assessment period, the question for the Tribunal is whether they met the applicable criteria on the facts existing at that time. In answering that question, it is not permissible for the Tribunal to have regard to later developments. While the Tribunal may have regard to evidence which comes into existence after the assessment period, this is relevant only insofar as it assists in establishing the true state of affairs during the assessment period.

### Diagnosed

1. In relation to the question of whether Mr Smith’s heart condition was fully diagnosed during the assessment period, the most relevant evidence before me is that of Dr Ivan Straznicky, Mr Smith’s treating cardiologist. Dr Straznicky has prepared a report dated 4 August 2014 and a letter dated 19 May 2015, and also gave oral evidence at the hearing.
2. In his oral evidence, Dr Straznicky confirmed that the current diagnosis of Mr Smith’s heart condition was *“treated valve disease”* and *“chronic atrial fibrillation”*. He indicated that the only change to the diagnosis since the assessment period was that, since then, Mr Smith’s valve disease had been treated with surgery, whereas, during the assessment period, the applicable diagnosis was simply valve disease and chronic atrial fibrillation.
3. In his report of 4 August 2014, in answer to the question of whether Mr Smith’s heart condition was fully diagnosed, treated and stabilised during the assessment period, Dr Straznicky wrote:

An echocardiogram in January 2013 ... showed a degree of aortic valve disease, a degree of mitral valve disease and a degree of left ventricular impairment although to be fair the severity of this disease did not declare itself fully until May [2014] ... the degree of valve disease had progressed significantly in between January 2013 and May 2014, between two echocardiograms.

...

He was treated adequately with medication for this period, that being heart rate control, anticoagulation, a trial of DC cardioversion which failed to revert him to sinus rhythm, and a monitoring of valve disease. Due to progression of symptoms and a progression of valve disease on echo, he has now been referred for double valve surgery ... but obviously this was not contemplated within the window period in your letter.[[5]](#footnote-5)

1. In his oral evidence, Dr Straznicky said that he suspected Mr Smith’s valve disease had been “*underdiagnosed*” in 2013 and that the initial echocardiogram had “*under-caught*” the degree of valve disease. He confirmed that a subsequent echocardiogram conducted after the assessment period, in May 2014, showed “*substantial*” valve disease which was subsequently treated with valve replacement surgery in August 2014. When he was asked whether Mr Smith’s heart condition had been fully diagnosed, treated and stabilised during the assessment period, Dr Straznicky said that the extent of the condition probably “*hadn’t been fully investigated*” in that the extent of the valve problem had not been identified, and that at that time he thought Mr Smith’s symptoms were primarily due to atrial fibrillation, rather than the valve problem. When pressed, however, the doctor conceded that he was “*pretty happy*” with the diagnosis made in 2013, which he was in the process of appropriately treating at that time.
2. It is significant, in my view, that Dr Straznicky acknowledged that valve disease does tend to progress, but was not able to say to what extent the ‘substantial’ valve disease identified in May 2014 was as a result of progression of the condition since 2013 as opposed to any ‘under-reporting’ or ‘underdiagnosis’ of the disease in 2013. Further, I note that the diagnoses of valve disease and atrial fibrillation have not changed since the assessment period, except to the extent that the valve disease has been found to be more extensive and has been treated with surgery.
3. I note also that the proper question for me is not whether there has been any change to Mr Smith’s diagnosis after the assessment period, but whether, on the facts as they existed during the assessment period, it was reasonable to conclude that the condition was fully diagnosed. It is clear that as at the assessment period, Mr Smith’s conditions had been investigated and he had been found to have valve disease and atrial fibrillation. Dr Straznicky was also *“pretty happy”* with the diagnosis, and as at September 2013 was not planning any further investigations.
4. In light of that evidence, I have concluded that I am satisfied that the condition was properly regarded as fully diagnosed during the assessment period, notwithstanding Mr Smith’s valve disease subsequently progressed and was later found to be more significant in degree than expected.

### Treated

1. Turning next to whether the condition was fully treated, I note the Secretary’s submission that surgery had not been performed to ‘cure’ the valve disease until August 2014. However, I note that surgery was not contemplated by any of the medical practitioners during the assessment period, and the proper question for me is whether the condition was correctly regarded as fully treated on the facts as they existed during the assessment period.
2. Dr Straznicky’s evidence was that “*it took a while for [it] to become clear*” that the valve disease would require surgery and that the plan in 2013 was to monitor the valves. Further, as at September 2013, Mr Smith had undergone or was undergoing all of the treatment recommended by Dr Straznicky, including cardioversion and diuretics, and there were no plans to adjust his treatment regime or try any additional treatment. Mr Smith’s evidence, which was not inconsistent with Dr Straznicky’s evidence, was that he was told at that stage he would not need valve surgery for another five years.[[6]](#footnote-6)
3. On the basis of the evidence before me, I am accordingly satisfied that, on the facts existing during the assessment period, the condition was appropriately regarded as fully treated at that time.

### Stabilised

1. Although Dr Straznicky initially indicated that the condition was not fully treated and stabilised during the assessment period, as I have indicated, when pressed he confirmed that diuretics had been trialled and found to be successful, and he had no plans to increase Mr Smith’s dose or trial any other treatment as at September 2013. Accordingly, I am also satisfied that the condition was fully stabilised during the assessment period, albeit it later became apparent that Mr Smith’s valve disease was worse than had been expected and, once this was discovered, surgery was undertaken.

### What is the applicable impairment rating?

1. I am satisfied that the appropriate table for the purposes of assessing an impairment rating for Mr Smith’s heart condition is Table 1 of the Impairment Tables, which relevantly provides as follows:

## Table 1 – Functions requiring Physical Exertion and Stamina

|  |  |
| --- | --- |
| Points | Descriptors |
| *5* | There is **mild** functional impact on activities requiring physical exertion or stamina.1. *The person:*
2. *experiences occasional symptoms (e.g. mild shortness of breath, fatigue, cardiac pain) when performing physically demanding activities and, due to these symptoms, the person has occasional difficulty:*
	* 1. *walking (or mobilising in a wheelchair) to local facilities (e.g. a corner shop or around a shopping mall, larger workplace or education or training campus), without stopping to rest; or*
		2. *performing physically active tasks (e.g. climbing a flight of stairs or mobilising up a long, sloping pathway or ramp if in a wheelchair) or heavier household activities (e.g. vacuuming floors or mowing the lawn); and*
3. *is able to perform most work-related tasks, other than tasks involving heavy manual labour (e.g. digging, carrying or moving heavy objects, concreting, bricklaying, laying pavers).*
 |
| *10* | There is **moderate** functional impact on activities requiring physical exertion or stamina.1. *The person:*
2. *experiences frequent symptoms (e.g. shortness of breath, fatigue, cardiac pain) when performing day to day activities around the home and community and, due to these symptoms, the person:*
	* 1. *is unable to walk (or mobilise in a wheelchair) far outside the home and needs to drive or get other transport to local shops or community facilities; or*
		2. *has difficulty performing day to day household activities (e.g. changing the sheets on a bed or sweeping paths); and*

*(b) is able to:**(i) use public transport and walk (or mobilise in a wheelchair) around a shopping centre or supermarket; and**(ii) perform work-related tasks of a clerical, sedentary or stationary nature (that is, tasks not requiring a high level of physical exertion).* |

1. In his report of 4 August 2014, Dr Straznicky noted that on 10 September 2013 (that being towards the end of the assessment period), “*having had diuretics, [Mr Smith] felt substantially better. This put him in the mild functional impairment level*.” During his oral evidence he clarified this by indicating that the answer he gave in his report was based on how he recalled Mr Smith to have presented to him on that occasion in September 2013.
2. However, Mr Smith gave detailed evidence at the hearing about the extent of his impairment. He said that he experiences heart palpitations 20 times a day and shortness of breath essentially with any activity. He said that his palpitations occur randomly and it takes him 10 minutes to *“breathe through”* one of these episodes. Mr Smith also described feeling out of breath when he walks around his home, for example from the bedroom to the bathroom or to the kitchen. The effect of his evidence was that he was also experiencing these symptoms during the assessment period, and has experienced them continuously since then, although since the surgery, despite continuing to feel out of breath, he has felt like “*a pillow has been taken away*” from his face.
3. In his oral evidence, Dr Straznicky confirmed that Mr Smith was experiencing breathlessness in 2013. Consistently with his written report, he said that by September 2013 (based on his recollection) Mr Smith reported his breathing had improved somewhat as a result of the diuretics. However, Dr Straznicky also said he did not think Mr Smith’s breathing had improved to normality, and under questioning by the Tribunal, he accepted that on the basis of Mr Smith’s report of his symptoms, together with his own observations of Mr Smith, it would be fair to say Mr Smith currently had a moderate impairment under Table 1, and had had this since June 2013.
4. As I accept Mr Smith’s evidence as to his symptoms during the assessment period, which I regard as corroborated by Dr Straznicky, I am satisfied that a 10 point rating under Table 1 was applicable throughout the assessment period.

## Other Conditions

1. For completeness, I note that Mr Smith’s claim for DSP also refers to the following conditions: ‘spleen out’ and hernia. However, Mr Smith’s General Practitioner, Dr Connolly, has indicated on the claim form that he regards those conditions as causing minimal or limited functional impact. Accordingly, even if I was satisfied that those conditions had been fully diagnosed, treated and stabilised, they would nevertheless attract a nil rating under the applicable Impairment Tables.

# Does Mr Smith have a continuing inability to work?

1. As I understand it, the Secretary does not dispute that Mr Smith has actively participated in a program of support and therefore satisfies subs 94(2)(aa) of the Act. However, the Secretary contends that as at the assessment period, Mr Smith did not have a continuing inability to work.
2. In some respects, this is the most difficult of the issues for me to determine, as there is very little evidence before me directed to it. The Secretary relies in particular on Job Capacity Assessment reports based on assessments undertaken on 20 June 2013 and 30 September 2013.[[7]](#footnote-7) Each of these assessed Mr Smith as currently able to work less than 15 hours per week, but having capacity to work 15-22 hours per week within two years with intervention, having regard to both his spinal and heart conditions.
3. However I must also take account of Mr Smith’s own evidence as to his condition during the assessment period, and in particular the degree of breathlessness he was experiencing. It is also relevant that Dr Connolly, Mr Smith’s General Practitioner, certified him unfit for work from 6 June 2013 to 6 September 2013[[8]](#footnote-8), and as at the assessment period, there was no medical evidence to suggest that Mr Smith’s work capacity was expected to improve. Further, during the hearing the Secretary did not suggest any work Mr Smith was likely to be able to undertake for 15 or more hours per week as at or within two years of the assessment period, or any training he could have undertaken which would have been likely to result in him working 15 hours per week in paid work within two years of the assessment period.
4. On the limited evidence before me, I have concluded that I am satisfied, on balance, that during the assessment period, Mr Smith had a continuing inability to work within the meaning of s 94, and therefore satisfied subs 94(1)(c) of the Act.

# Conclusion

1. As I have found that Mr Smith satisfied subss 94(1)(a), (b) and (c) of the Act during the assessment period, I have accordingly decided to substantially affirm the decision under review. However, having regard to Dr Straznicky’s evidence that it was not until 10 September 2013 that Mr Smith could be said to have trialled and been placed on a stable dose of diuretics, I have decided that I should vary the decision under review so as to provide that Mr Smith satisfied the qualification requirements contained in subss 94(1)(a), (b) and (c) of the Act from 10 September 2013. Aside from that variation, I otherwise affirm the reviewable decision of the SSAT.

# DECISION

1. The decision under review is:
	1. varied so as to provide that Mr Smith satisfied the qualification requirements for disability support pension contained in subss 94(1)(a), (b) and (c) of the *Social Security Act 1991* only from 10 September 2013; and
	2. otherwise affirmed.

|  |
| --- |
| I certify that the preceding 40 paragraphs are a true copy of the reasons for the decision herein of Deputy President K Bean |

....... [Sgd] .........................................

Associate

|  |  |
| --- | --- |
| Dated 10 August 2015Dates of hearing | **6 and 14 July 2015** |
| Counsel for the Applicant | **Mr B Dubé** |
| Solicitors for the Applicant | **Sparke Helmore Lawyers** |
| Solicitors for the Respondent | **Welfare Rights Centre (SA) Inc.**  |

1. *Social Security (Administration) Act 1999*, Schedule 2, clause 4. [↑](#footnote-ref-1)
2. [2012] AATA 922, at [34]. [↑](#footnote-ref-2)
3. (2014) 144 ALD 133. [↑](#footnote-ref-3)
4. At p 230. [↑](#footnote-ref-4)
5. Exhibit 6. [↑](#footnote-ref-5)
6. Critically therefore, as at the assessment period, aside from a continuation of treatment to manage the condition, and ongoing monitoring, no further treatment was planned within two years, pursuant to subsection 6(5) of the Determination. [↑](#footnote-ref-6)
7. Exhibit 1, T20 and T21. [↑](#footnote-ref-7)
8. Exhibit 1, T19/210. He was subsequently certified unfit until 30 November 2013 : T21/234. [↑](#footnote-ref-8)