Determination Number: CA 101/06
File Number: CEA 394/04

Under the Employment Relations Act 2000

BEFORE THE EMPLOYMENT RELATIONS AUTHORITY
CHRISTCHURCH OFFICE

BETWEEN	Karyn Dillon (Applicant)
AND	Tip Top Ice Cream Company Limited (Respondent)
REPRESENTATIVES	Kay Stringleman, Advocate for Applicant Jennifer Mills, Counsel for Respondent
MEMBER OF AUTHORITY	Philip Cheyne
INVESTIGATION MEETING	12 and 13 December 2005 14 and 15 March 2006
SUBMISSIONS RECEIVED	24 March and 10 April 2006 from the Applicant 31 March 2006 from the Respondent
DATE OF DETERMINATION	7 July 2006

DETERMINATION OF THE AUTHORITY

Employment relationship problem

[1] Karyn Dillon has worked for Tip Top from February 1995, initially part time, and then full time from August 1995. She had accidents at work in February 2000, September 2002 and September 2003. The September 2002 accident resulted in a surgical reconstruction of her right shoulder and eventually a return to work initially on limited hours and light duties but later subject only to light duties. Following the September 2003 accident, Ms Dillon initially continued work but from November 2003 was certified medically unfit for work. Ms Dillon has not worked at Tip Top since but Tip Top has not terminated her employment. The current problem is about whether Ms Dillon is entitled to a payment under a clause in the applicable Collective Employment Agreement.

[2] Clause 33.3 of the Collective Employment Agreement reads:

> *In cases whereby OSH or the Courts deem the company liable for a worker becoming permanently unfit for work as a result of a work-related accident, or where the company admits liability, the company shall make a severance payment. This payment will be based on the redundancy compensation scale as prescribed in clause 47.7 less any payment awarded by the Courts to the worker.*

[3] Ms Dillon says that she is entitled to this payment because Tip Top admitted liability by accepting that her accidents were work-related and that the medical evidence establishes that she is permanently unfit for work.

[4] Tip Top says that neither OSH nor the Courts have deemed it liable, that it has not admitted liability and in any event that Ms Dillon has not established that she is permanently unfit for work. Ms Dillon says that Tip Top should not be allowed to take the point that liability imports the concept of fault because it has only been raised in the submissions lodged after the investigation meetings ended.

[5] It will be helpful to start by a fuller but not comprehensive outline of events since the September 2003 accident. Consideration will be given to the interpretation of the relevant part of the Collective Agreement which will then be applied to the facts as found to exist.

Events since September 2003

[6] Dale Carr is Ms Dillon's team leader. He completed an accident investigation report following Ms Dillon's accident of 30 September 2003. The form records *slipped on concrete and went down. Slipped between vat 17 and uni-vats, hit right shoulder on uni-vats and left arm from elbow on concrete floor. Floor area slippery and dangerous.* He noted that the injury was work-related. He also recorded *coating of floor surface now smooth when wet becomes slippery. Floor area concerned will be resurfaced during Labour Weekend shutdown.* It is not mentioned by Mr Carr but Ms Dillon's evidence (supported by contemporaneous documents) is that her fall was associated with a minor earthquake.

[7] On 2 October 2003, Ms Dillon saw her doctor who recommended 2 weeks off work but Ms Dillon resisted this because of financial pressures. She took one day off on 3 October 2003. Ms Dillon saw an occupational physiotherapist on 7 October as a follow-up to her earlier surgery following the 2002 accident and her gradual return to fuller duties. The physiotherapist reported the September 2003 accident to Ms Dillon's case manager, Kathy Romanes, of CRM Group Limited. CRM provides injury management services for Tip Top which is an accredited employer under the Injury Prevention Rehabilitation and Compensation Act 2001. The physiotherapist's report noted that Ms Dillon had *very restricted shoulder movements with flexion to approximately 45 degrees and abduction to approximately 30 degrees. [Ms Dillon] was very reluctant to move due to pain.* There is no reason to doubt the accuracy of the report even though Ms Dillon's pain was not apparent to others she worked with through this time. That reflects stoicism on Ms Dillon's part.

[8] On 13 October 2003, Ms Dillon had an x-ray and ultrasound of her right shoulder. On 24 October 2003, she saw Mr Penny, the surgeon who had operated on her right shoulder after the September 2002 accident. He arranged for an MRI scan. Judith Mair is Tip Top's South Island operations manager. She was made aware of these developments.

[9] Ms Dillon saw her doctor again on 10 and 17 November 2003. The doctor's notes record Ms Dillon's view that her shoulder was wrecked and by 17 November 2003, she was asking her doctor for a letter in support of severance. Some days earlier, Ms Dillon had learnt from her union delegate about the payment provided for at clause 33.3 of the Collective Agreement. Ms Dillon asked Dr Day to provide a letter supporting her intended application for severance pay. Ms Dillon wrote a letter of application on 18 November 2003 and supported it with Dr Day's letter of the same date. These letters were delivered to Ms Mair on 20 November 2003. Ms Mair was not surprised by the application because it had been mentioned to her some days earlier by a union delegate.

[10] Although Ms Dillon knew nothing of it by this time, Ms Mair had also received a complaint about her cleaning of production equipment. The complaint was about a failure to work to required standards in respect of work done on 19 November 2003. Ms Dillon had received a written warning on 16 September 2003 for a similar incident. Ms Mair convened a disciplinary meeting on 21 November 2003 to investigate the complaint. Ms Dillon wanted to discuss her severance

application but Ms Mair focussed on the disciplinary investigation. There was a second disciplinary meeting on 24 November. Ms Dillon was told that she would be issued with a final written warning and would be relocated from nightshift to either day or afternoon shift depending on her preference to perform packing duties under greater supervision.

[11] On 25 November 2003, Dr Day certified Ms Dillon as medically unfit for work for 14 days from 24 November 2003. Before that, Dr Day and Ms Mair had both phoned one another but had to leave messages. Ms Mair sent a fax to Dr Day on 27 November 2003 saying that Tip Top was committed to Ms Dillon's rehabilitation with severance considered only as a last resort. Ms Mair also referred to Tip Top's decision to move Ms Dillon off nightshift to alternative duties and asked for Dr Day's view about what duties Ms Dillon was capable of without causing further damage to her shoulder. Dr Day responded by facsimile saying that she would refer the question about work capability to the orthopaedic surgeon for comment once the MRI scan had been done.

[12] In the meantime, CRM had referred the file to its branch medical advisor for a recommendation. On 5 December 2003, he recommended a referral to an occupational medical specialist to confirm that Ms Dillon was unable to continue in her current position and to look at recommendations for ongoing rehabilitation. On 12 December 2003, the orthopaedic surgeon reported on his examination of Ms Dillon and the results of the MRI scan. He reported a *full thickness tear of supraspinatus* but did not recommend further surgery. The report states …*I think it might be best to ignore the tear and advise her to keep working at rehab and perhaps look at an occupational change.* The surgeon also commented that an occupational therapist with work site experience would be best placed to assess her capability to do the proposed packing work.

[13] Dr Christopher Strack is an occupational physician and CRM referred Ms Dillon to him for a report on her diagnosis, recommendations about treatment and comment on her fitness for work. Dr Strack saw Ms Dillon on 7 January 2004. Dr Strack's opinion was also informed by various reports. His diagnosis was of a *right frozen shoulder*. He noted the impact of significant stress and/or depression and reported that Ms Dillon presented with quite a catastrophic picture. He recommended an urgent referral to a multi-disciplinary pain management unit. Dr Strack considered that Ms Dillon was unfit for …*virtually any form of work. [but] … her fitness for work will hopefully improve in the future.* He assessed Ms Dillon as unlikely to be able to return to her employment in the near to medium future and that … *vocational redirection to some form of lighter vocational activity* … would be appropriate.

[14] As a result of Dr Strack's recommendation, Ms Dillon was referred to the Burwood Pain Management Centre. Ms Dillon first attended the Burwood Centre in late January 2004, following which a programme was developed. A progress reported dated 9 April 2004 says that Ms Dillon attended all sessions, engaged in the material presented and made some small physical progress. However, the completion report dated 18 May 2004 records that outcomes were not achieved despite six physiotherapy, seven occupational therapy and eight clinical psychology sessions. Ms Dillon's focus on disputes between her, Tip Top and CRM was seen as a significant barrier to progress.

[15] On 10 February 2004, CRM referred Ms Dillon to career services for an initial occupational assessment. Ms Dillon's GP wrote to CRM questioning the purpose of this, given Dr Strack's report and the Burwood Centre referral. However, an appointment was arranged for 2 March 2004. The service provider stopped that session after about 20 minutes due to Ms Dillon's *lack of engagement*. There is an email from the service provider to CRM describing what happened. I see no reason to doubt the accuracy of that description despite Ms Dillon's evidence on the point. CRM sent an email to Ms Dillon explaining that the occupational assessment was required as part of the vocational independence programme, given Dr Strack's opinion that Ms Dillon would be unable to return to work in her current position. A similar explanation was given in a letter responding to

Dr Day's letter. That letter also indicates that the Burwood Pain Management Centre saw no difficulty with Ms Dillon's involvement in the vocational independence programme at the same time as their programme. Following this, career services completed the initial occupational assessment report and identified various work options for Ms Dillon in light of her work history.

[16] Ms Dillon was next referred to Dr Keith Murray for an initial medical assessment as part of the vocational independence process. Arrangements for this were made in May 2004 and Ms Dillon saw Dr Murray on 9 June 2004. Dr Murray's opinion was that Ms Dillon was physically able to undertake types of work involving use of her left arm and left hand but her depression meant any type of work was currently unsustainable. All the work options identified by Career Services were said to be not currently sustainable. Dr Murray referred to the need to have the *litigation issue* with Tip Top resolved and noted that Ms Dillon was at risk of losing the use of her right hand and arm forever. Dr Murray recommended a referral to a psychiatrist.

[17] By the time of Dr Murray's report, there has been an exchange of correspondence between Tip Top and Ms Dillon's representative about a *litigation issue.* Tip Top wrote to Ms Dillon's union on 17 February 2004 in response to an information request and made it clear that it had deferred finalising the shift transfer part of the final warning because Ms Dillon was fully unfit for work. Next, Ms Dillon's representative wrote on 4 March 2004 advancing the claim for payment under clause 33.3 of the Collective Agreement on the strength of Dr Strack's report. Tip Top replied on 15 April 2004 saying that Ms Dillon was not eligible for the payment under clause 33.3 because she was not permanently unfit for work. Reference was made to Dr Strack's expectation that Ms Dillon would return to more normal levels of functioning and the agreed rehabilitation objective for Ms Dillon to return to full practice and her previous employment by 30 October 2004. Ms Dillon's representative responded on 28 June 2004. The present proceedings were eventually lodged with the ERA on in October 2004 following an unsuccessful mediation in August 2004.

[18] In the meantime, there was action on Dr Murray's recommendation of a referral to a psychiatrist. CRM arranged a referral to Dr Harvey Williams who was asked to report on Ms Dillon's ability to participate in vocational rehabilitation, her ability to return to work at Tip Top and her ability to return to work in the future. Dr Williams provided a first report on 20 July 2004 and diagnosed Ms Dillon as having a major depression with major anxiety features. His opinion was that Ms Dillon was currently unable to participate in vocational rehabilitation. He expected that Ms Dillon should be able to return to work at Tip Top but queried in what capacity, given that a return to full orthopaedic functioning appeared unlikely, and Ms Dillon's view of her employer. The report detailed the anti-depressant medication being trialled for Ms Dillon.

[19] There followed a social rehabilitation process that resulted in the provision of some home support. CRM also sought advice from Ms Dillon's GP about the time that might be required to implement the treatment designed to reduce Ms Dillon's anxiety before further vocational rehabilitation might be considered. Dr Day's locum responded indicating that Ms Dillon was unlikely to be well enough to consider vocational rehabilitation before January 2005. Next, CRM sought a file review from the branch medical advisor (Dr Moughan) about Tip Top's liability for the *psychological issues* and how that might be investigated further. Dr Moughan provided a report dated 5 September 2004 and pointed out that there was no evidence that the ongoing incapacity was not injury related and that there was no evidence of pre-existing psychological issues.

[20] In March 2005, Ms Dillon was seen again by Dr Robinson at the Burwood Pain Management Centre. He concluded that there was no specific medical cause for her inability to move her right arm and felt that the problem was probably psychological and most likely a conversion disorder. His examination revealed no muscle wasting of the right arm but some mild wasting around the shoulder girdle. He reported that a …*lack of muscle wasting is not consistent with what is normally found in a person who is not voluntarily moving their arm.*

[21] In evidence, Ms Dillon challenged a number of the statements made by Dr Robinson in his March 2005 report. In particular, she disputes the observed lack of muscle wasting and that she reported no pain at the time of the examination. In response, Dr Robinson's evidence is that he recalls being surprised at the time by the reported lack of pain and that Ms Dillon also offered an explanation for the lack of muscle wasting, implicitly confirming his observation. Despite Ms Dillon's evidence, I see no reason to doubt Dr Robinson's evidence and prefer it where there is a conflict. Having said that, Dr William's evidence is that an effect of Ms Dillon's anti-depressant medication at the time would be a reduction in pain.

[22] Dr Williams was asked to comment on Dr Robinson's report, which he did, on 20 April 2005. He noted that Dr Robinson was raising the possibility that Ms Dillon was malingering. He questioned whether Dr Robinson should be specifically asked if that was his primary diagnosis. He agreed with Dr Robinson that *theoretically with intense psycho social management and rehabilitation, it should be possible to move the arm again, but I feel this is unlikely*. Dr Williams conveyed Ms Dillon's comment that Dr Robinson must have misunderstood or misheard her comments about pain. He also noted that Ms Dillon's current anti-depressant medication may be affecting the amount of pain registered by Ms Dillon. Dr Williams repeated his original diagnosis of a major depressant disorder with major anxiety features which was likely to continue while the settlement issues were unresolved. He finally noted that a full recovery was unlikely.

[23] Following the receipt of Dr Robinson's report, Tip Top instructed a private investigator to observe Ms Dillon. The surveillance commenced on 11 April 2005 and ended on 21 April 2005. The surveillance did not produce any evidence that Ms Dillon was able to use her right arm. Ms Dillon and her partner say that they first noticed the private investigator on 12 April 2005 and thought on 13 April 2005 that he was surveilling them. That was apparently confirmed on 15 April when the police reported to them that the private investigator held a current licence. In a statement dated 11 May 2005, the private investigator calls into question Ms Dillon's claim that the police confirmed she was under surveillance. However, Ms Dillon knew by 20 April 2005 at the latest of the surveillance on her because that is referred to by Dr Williams in his report of that date.

[24] Following these events, there was a meeting on 28 June 2005 between Ms Dillon, Mr Searle (Ms Dillon's partner), Dr Day, Dr Williams, Ms Mair and Ms Bates (CRM) to establish a rehabilitation plan. There is some conflict in the evidence about the conduct of Ms Dillon and Ms Mair towards one another at this meeting. However, I accept Dr Williams' evidence that there was no shouting but signs of hostility and acrimony by both Ms Dillon and Ms Mair towards one another. The meeting resulted in an agreement for Ms Dillon to undertake an assessment by the OccMed Unit from the University of Auckland. It was agreed that both Dr Day and Dr Williams would continue to monitor Ms Dillon's medication and home help support was to continue in the meantime. Ms Dillon was concerned about an approach from a debt collection agency (mistakenly referred to as Baycorp) for some treatment costs and there was an agreement to investigate that.

[25] Initially Ms Dillon objected to travelling to Auckland although Tip Top were prepared to fund the travel costs for her partner to accompany her. When it was pointed out to Ms Dillon that she was required to participate in relevant assessments, Ms Dillon relented. However, Dr Day sent an email to CRM advising that the medication required for Ms Dillon to cope with air travel would compromise any assessment and proposed a referral to a Christchurch based specialist. Nonetheless, CRM and Tip Top decided to seek a report from the OccMed Unit by way of file review in the first instance. CRM sent relevant medical and rehabilitation file material to the OccMed Unit and specifically asked for comment on some degenerative changes referred to by Dr Strack, whether the diagnosed mental injury related to the original injury of supraspinatus tear and the relevance of the reported *employer issues* as a barrier to ongoing rehabilitation pending the recommendations. Tip Top followed up with its own letter dated 6 September 2005 to the OccMed Unit. Tip Top took the opportunity to set out its view about the September and November 2003

warnings, Ms Dillon's claim for a payment under clause 33.3 of the Collective Agreement, exerts from the various specialists reports and whether Ms Dillon was then permanently unfit for work. While Tip Top's action might seem unusual, it must be remembered that an investigation meeting had been scheduled for 27 and 28 September 2005, later adjourned to dates in mid December 2005.

[26] The OccMed report by Dr Scott and Dr Callaghan is dated 28 September 2005. They found that any degenerative change was of minor or no clinical significance. They concluded that *…Ms Dillon appears to have developed a chronic pain syndrome (with features of CRPS in 2003) secondary to a muscular skeletal injury with depression and anxiety as a consequence of this condition*. They also concluded that conversion disorder could not be confirmed in the presence of a chronic pain syndrome. The report noted that dispute should not preclude the start of rehabilitation and delay can impact negatively on prognosis. Finally, there were no specific recommendations for ongoing management of the injury given that the OccMed Unit's role was limited to a file review.

[27] Subsequently on 8 December 2005, Dr Adams from the OccMed Unit saw Ms Dillon for an assessment. That resulted in a reported dated 20 February 2006. The report summarised the situation as follows:

> *Karyn is a 47 year old woman with chronic pain affecting the right arm following a fall in 2000. There are documented signs and symptoms from previous reports to support a diagnosis of complex regional pain syndrome. The positive findings on examination today are the presence of allodynia, increased hair growth and possible skin temperature symmetries in Ms Dillon's right arm. Karyn also describes significant mental health issues which she feels have not improved despite intervention.*

[28] I should note that the attribution of the symptoms to a fall in 2000 is not correct. It appears that Dr Adams was told by Ms Dillon that the onset of her chronic pain dates from the first accident in 2000. However, there is no other information to support this. Ms Dillon had only a brief time off work as a result of the 2000 accident and every other indication is that she recovered from that event. File information also indicates that Ms Dillon's recovery from the September 2002 accident and subsequent surgery was progressing but more slowly than originally expected when the September 2003 accident occurred. The OccMed Unit recommended a case conference with relevant health professionals.

[29] To complete the summary of events following the September 2003 accident, I should record that Ms Dillon applied for lump sum compensation under the Injury Prevention, Rehabilitation and Compensation Act 2001. Ms Dillon was referred to Dr Schousboe who produced an assessment report after seeing Ms Dillon on 31 January 2005. Dr Schousboe first reported that Ms Dillon's condition was neither permanent nor stable clinically but met the ACC's stability criteria. In an amended report, he recorded that the position was stable in terms of ACC criteria, that such conditions were notoriously difficult to treat and that recovery is very unlikely. Dr Schousboe noted that the case transcended the boundaries between physical and mental injuries with neither medical technique having the capacity to describe the condition accurately. However, Dr Schousboe found that Ms Dillon had absolutely no use of her right arm which he assessed as a permanent impairment in terms of the ACC criteria. Dr Schousboe was subsequently asked to comment on whether the current condition was attributable to the February 2000 accident and was provided with further file material. Dr Schousboe found good evidence that the February 2000 injury had not contributed to the current impairment. Dr Schousboe was asked again to reconsider his view and was provided with some additional documentation. Dr Schousboe preferred to place weight on the records from medical specialists who had seen Ms Dillon rather than her current account of pain and mentioned his view about the lack of relevance of the February 2000 accident. I agree with Dr Schousboe that Ms Dillon's relatively recent reports of pain since February 2000 should not be preferred to the

records which show a recovery from the February 2000 accident. Tip Top sought a review of the decision to pay Ms Dillon lump sum compensation following Dr Schousboe's reports but the reviewer upheld the ACC decision.

[30] Under the Collective Agreement, Tip Top provides death and disability insurance cover for work accidents. Tip Top's insurer is AIG. Ms Dillon initiated a claim with AIG in about December 2004. She was referred to Dr Xianghu Xiong for a specialist report. He saw Ms Dillon on 25 May 2005 and wrote a report the same day. He favoured a diagnosis of a complex regional pain syndrome Type 1 related to the two later accidents and a probable development of frozen shoulder/adhesive capsulitis. However, he noted that her clinical features were not typical of CRPS or a conversion disorder. He considered it unlikely that the condition would improve to any significant degree. However, he did not rule out potential improvement of her right arm and hand function since there was no pathological basis apart from the frozen shoulder for the loss of movement especially to the elbow, wrist, hand and fingers. As a result of the assessment, Ms Dillon received a payment under Tip Top's AIG policy.

[31] In evidence, Tip Top notes that AIG did not contact it in respect of Ms Dillon's claim and Ms Mair expresses surprise that a payment was made in light of Dr Xiong's comment that he could not rule out potential improvement. I should note that there was no obligation on the part of Ms Dillon to advise Tip Top of her claim.

The parties' submissions

[32] The argument for Ms Dillon can be summarised as follows. Ms Dillon says that she must establish that Tip Top admitted liability and that she is permanently unfit for work. Tip Top admitted liability for the work-related accident by its claims administrator (CRM) accepting that Ms Dillon was covered under the IPR&C Act 2001. *Permanently unfit for work* means permanently unfit for work at Tip Top. That arises by interpreting clause 33.3 in context, given the reference to a severance payment, and the Collective Agreement being about the relationship between the employee and Tip Top. *Permanently* should be determined by the medical evidence and by reference to other relevant definitions such as the ACC legislation and the AIG insurance policy.

[33] Tip Top says that Ms Dillon is not entitled to payment under clause 33.3 because neither OSH nor the Courts have deemed Tip Top liable for the work-related accident; Tip Top has not admitted liability; the Authority cannot be satisfied that Ms Dillon has become permanently unfit for work; Ms Dillon is not unfit for work; and it is not possible to identify the work-related accidents suffered by Ms Dillon as the cause of any established impairment.

[34] Tip Top says that clause 33.3 is intended to capture cases where an employee is rendered permanently incapable of work by a workplace accident that the employer has caused or is otherwise at fault for. That arises from the natural and ordinary meaning of the words *liable* and *liability* and gives the whole of clause 33.3 a proper purpose. *Permanently* is properly defined by reference to common dictionary definitions to include something lasting indefinitely rather than temporarily. The point is made that both the ACC legislation and the AIG policy document include their own definitions so they are unhelpful here. Tip Top says that Ms Dillon cannot establish her impairment as permanent because there is no correct diagnosis so there cannot be an accurate prognosis, that Ms Dillon exaggerates her symptoms making medical appraisals unreliable, that she has failed to meaningfully participate in rehabilitation and that she acknowledges that she is not permanently impaired. Tip Top concedes that *unfit for work* means unfit for work at Tip Top but says that *work* refers broadly to any occupation not just to Ms Dillon's former position. It is said that Tip Top has work for a person with one arm for example, as a telephonist or data entry type roles. Tip Top also says that Ms Dillon cannot establish that her current impairment, including

depression, is the result of work-related accidents. Tip Top says that the evidence indicates other causes.

Interpreting and applying the Collective Agreement

[35] See *ASTE v Chief Executive of Bay of Plenty Polytechnic* [2002] 1 ERNZ 491 for a summary of the proper approach to interpretation of collective employment agreements. Agreements should be interpreted with reference to their factual matrix including matters such as the background to the transaction. One must look at the words used by the parties, and at the surrounding circumstances to make sure that the meaning is correct and that nothing in the circumstances requires modification of that most natural meaning. What is required is an objective approach to interpretation of the final agreement. Evidence is not admissible of what a party thought the words meant or of preliminary negotiations or earlier drafts. The interpretation of an agreement should not be narrowly literal but should be in accord with business common sense. The interpretation should fulfil the purpose of the agreement even if the drafting is inept. However, if the words are clear and can have only one possible meaning, that should generally determine the matter.

[36] Clause 33 is one of 9 clauses in a section of the collective agreement headed *Part XIII – Occupational Health and Safety*. Clause 33 itself is headed *PAYMENT FOR WORK RELATED INJURY*. The first subsection of clause 33 entitles any worker who is off work due to a work-related injury to receive 100% of their wages during the first week's absence. It modifies the general entitlement under the ACC regime. The second subsection extends that enhanced entitlement for a longer period in certain circumstances. The third subsection is the disputed provision. The fourth subsection requires Tip Top to consult before changing the status quo in respect of ACC cover. It is clear from this that the parties intended the provisions in clause 33 to be read alongside and interpreted in the light of New Zealand's statutory regime currently set out in the IPR&C Act 2001. That has been a no fault scheme since 1974 when the first Act came into force. In light of that, the first question is whether the parties intended to introduce fault as a necessary ingredient before there could be any entitlement under clause 33.3 by use of the words *liable* and *liability*. In answering that question, I should bear in mind that collective agreements generally are not drafted by lawyers: see *Secretary for Education v. NZEI* [2002] 2 ERNZ 470.

[37] The drafting of clause 33.3 is imprecise. *OSH* could be a reference to the Health and Safety in Employment Act 1992, the service of the Department of Labour that administers the Act or inspectors appointed under the Act. Whichever, *OSH* has no power to deem Tip Top liable for a worker becoming permanently unfit for work. *Courts* could refer either to the Courts with jurisdiction for offences and enforcement action in respect of the Act or could refer more generally to any legal forum with power to make an enforceable ruling related to the issue at hand. *Liable* and *liability* defined by the *Oxford Concise English Dictionary* as *responsible by law* could have a more technical meaning requiring fault or might just reflect that the HSE Act 1992 and the IPR&C Act 2001 make an employer responsible for workplace accidents however caused. Even read narrowly, as I am now urged to do by Tip Top, the meaning is problematical. If an inspector lays an information or issues an infringement notice against the company, that might be taken as deeming Tip Top liable or to blame. The use of *or* then makes the actual finding of the Court on the charge irrelevant for the purposes of clause 33.3.

[38] It is improbable that parties such as a union and a major employer would have intended to introduce fault as an essential ingredient when negotiating enhancements to the compensation available under the no fault ACC system. The reference to *OSH* and the *Courts* is necessary to give sense to the last sentence of the subclause which is intended to avoid double dipping where there has been a prosecution and a reparation order. That leaves situations where the company *admits liability* or responsibility by law. The law in New Zealand is a no fault regime. It follows that there

need only be a workplace accident for which the employer has accepted responsibility or a finding to that effect. By reference to the surrounding circumstances under which the parties concluded their agreement, I find that there was no intention to require a worker to establish fault on the part of the company for a workplace accident before clause 33.3 can apply.

[39] There is substantial merit in the point made on behalf of the applicant that the respondent should not be permitted to argue for a fault requirement given that this was first raised in closing submissions lodged after the investigation meeting. However, given the finding above, it is not necessary to deal further with the point for present purposes.

[40] Having decided that it is unnecessary for Ms Dillon to establish that Tip Top was at fault for the accident as an essential ingredient for the application of clause 33.3, I must next consider whether Ms Dillon has become *permanently unfit for work as a result of a work-related accident.* There are several aspects that need to be considered. Is Ms Dillon's condition permanent? Is Ms Dillon unfit for work at Tip Top? Is her situation the result of a work-related accident?

[41] I find that Ms Dillon's situation is the result of a work-related accident. Tip Top argues that the absence of an adequate diagnosis or a prognosis for Ms Dillon means it is not possible to find that any established impairment is the result of work-related accidents. Reference is also made to evidence of other factors in Ms Dillon's life said to be the cause of what impairment she might have. It is unnecessary to set out here the evidence about other factors. Dr Williams and Dr Day are the two health professionals best placed to assess their relevance to Ms Dillon's current impairment. Both doctors are clear that Ms Dillon's impairment is not the result of the various other events in her life. All the medical specialists who have examined Ms Dillon have attributed her impairment, including the depression, to workplace accidents. Ms Dillon's situation may be complex and her symptoms atypical but there is little doubt that they result from the workplace accidents.

[42] The more difficult point is whether Ms Dillon has become permanently unfit for work at Tip Top. Tip Top believes that Ms Dillon is faking or at least exaggerating her symptoms to secure the payment under the collective agreement. Tip Top is very critical of Ms Dillon and says that she did not engage with rehabilitation processes. For example, I am referred to the lack of progress despite efforts by the Burwood Pain Management Centre, the difficulty with Career Services, differences in Ms Dillon's evidence such as the more recent reports of continuous pain since 2000, Dr Robinson's March 2005 report and the expert evidence of Professor Gorman that the probable explanation for the reported lack of muscle wasting is that Ms Dillon is moving her right arm.

[43] The health professionals who have examined Ms Dillon generally express some optimism that she might regain some function on her right arm and hand. However, they mostly are clear that a change of occupation will be required whatever function Ms Dillon might actually regain. Dr Day, Mr Penny, Dr Strack, Dr Murray, Dr Williams, Dr Schousboe, and Dr Xiang all support that view. Dr Murray in particular was asked to assess Ms Dillon's work capacity for alternative positions following the Career Services report.

[44] What is clear is that Ms Dillon will never return to work at Tip Top in any capacity even if she does eventually regain some capacity for work. The evidence of Ms Mair at the investigation meeting about work opportunities at Tip Top for Ms Dillon even with only one arm lacks reality. Ms Dillon must be assessed as permanently unfit for work at Tip Top even if she does regain some function. The evidence also supports the conclusion that while Ms Dillon's is a complicated and atypical case, her impairment is properly attributable to her workplace accidents and the associated depression. These are the very circumstances in which the parties to the Collective Agreement intended a severance payment to be made without blame being attributed to any party. Ms Dillon is entitled to a severance payment.

Summary

[45] For the foregoing reasons, I find that Ms Dillon is entitled to the payment provided at clause 33.3 of the Collective Agreement. No-one addressed any issue about calculating the quantum of the payment so I will leave that to the parties but leave is reserved if there is any difficulty.

[46] Costs are reserved. Ms Dillon's representative included some submissions on costs in her written submissions but the respondent did not take up the invitation to respond. Accordingly, the respondent may now have 14 days to make any submissions about costs and the applicant may have a further 7 days to lodge any further submission in reply.

[47] This matter has taken a long time to get to this point. It is a difficult case, there is a mass of documents and unfortunately my attendance to other matters has also delayed finalising a determination. I regret the delay and would like to acknowledge the parties' assistance.

Philip Cheyne
Member of Employment Relations Authority