IN THE COUNTY COURT

OF VICTORIA

AT MELBOURNE No. 2001/01975

B E T W E E N:

TREVOR OWEN BROWN

Plaintiff

– and –

STATE OF VICTORIA

Defendant

BEFORE HIS HONOUR JUDGE FAGAN

The 30th day of May 2001

REASONS FOR JUDGMENT

This is an application for leave to bring proceedings for non-pecuniary and pecuniary damages under s.135A(4)(b) of the *Accident Compensation Act* 1985.

The plaintiff is very ill from a medical condition said to have arisen out of passive smoking in the workplace. There is no question that he has a "serious injury" as is required by s.135A(6) for the purposes of bringing this application and as that expression is defined by s.135A(19) and is to be understood. I do not need to describe at this point his symptoms as set out in his affidavit sworn 9 March 2001, Paragraph 9.

The question is whether he should have leave to bring proceedings.

To recover damages after obtaining leave pursuant to s.135A(4)(b) the plaintiff must show:

1(a) That the injury complained of arose after 4 p.m. on 31 August 1985 (s.4(1) of the *Accident Compensation Act* – date of commencement of operation of the Act);

1(b) That the injury arose out of or in the course of or due to the nature of employment (s.135A(1) or (2));

1(c) Either, if employment of that nature was a significant contributing factor to an injury, it is a serious injury and arose on or after 1 December 1992 (s.135A(2)(a)) but not between 12 November 1997 and 20 October 1999 (s.134A), or, if the injury was a serious injury and arose before 1 December 1992, the incapacity arising from the injury did not become known until 1 December 1992 or a later date (s.135A(2)(b)).

"Injury" is defined by s.5 of the Act, unless inconsistent with the context or subject matter:

> " **"injury"** means any physical or mental injury and without limiting the generality of the foregoing includes—
>
> ...
>
> a. a disease contracted by a worker in the course of the worker's employment whether at or away from the place of employment and to which the employment was a significant contributing factor;
> b. the recurrence, aggravation, acceleration, exacerbation or deterioration of any pre-existing injury or disease where the worker's employment was a significant contributing factor to that recurrence, aggravation,

acceleration, exacerbation
or deterioration."

"Serious injury" is defined in s.135A(19):

" **"serious injury"** means—

a. serious long-term impairment or loss of a body function; or

... "

So far as the present case is concerned, s.135A(4) provides that a person may not bring proceedings for the recovery of damages in respect of the injury unless:

"(b) a court, on the application of the worker ... gives leave to bring the proceedings."

It was also argued for the plaintiff that he was entitled to bring proceedings (subject to leave under s.135A(4)(b)) for recovery of damages, irrespective of the date on which the injury arose, by virtue of s.82(6) of the Act, which reads:

"Where a worker suffers an injury which occurs by way of a gradual process over time and which is due to the nature of employment in which the worker was employed and if employment of that nature was a significant contributing factor at any time before notice of the injury was given, the worker ... shall be entitled to compensation under this Act as if the injury were an injury arising out of or in the course of employment."

or by virtue of s.86, which reads:

"If—

a. a worker is suffering from a disease within the meaning of
section 5 which incapacitates the worker from

> earning full wages at the work at which the worker was employed;
>
> ...
>
> and the disease is due to the nature of any employment in which
> the worker was employed and if employment of that nature was a significant contributing factor at any time prior to the date of incapacity, the worker or the worker's dependants shall be entitled to compensation in accordance with this Act as if the disease were an injury."

The medical condition from which the plaintiff suffers is described as emphysema, asthma, chronic bronchitis, bronchiectasis. That it is serious is beyond doubt. The applicant is at the top of the Alfred Hospital list of those persons awaiting a double lung transplant.

The applicant's case for recovery of damages is resisted by the defendant on the basis that:

a. The injury, albeit a "serious injury", is not shown to have arisen after
   31 August 1985 (s.4(1) of the *Accident Compensation Act* – the date of its operation);
b. That it is not shown by the applicant that this "serious injury" is one "arising out of or in the course of, or due to the nature of, employment"
   (as required by s.135A(1) or (2));
c. That "if employment of that nature was a significant contributing factor" that it was not shown that the injury was a serious injury and arose on or after 1 December 1992 (section 135A(2)(a)), nor that "if the injury arose before that date ... the incapacity arising from the injury did not become known until that date or a later date" (s.135A(2)(b)), nor, if the injury arose after 31 August 1985 out of or in the course of or due to the nature of

employment, that it did not arise on or after 12 November 1997 but before 20 October 1999 (s.134A(1)).

Although the defendant, in resistance to the plaintiff's claim for the recovery of damages, maintains the arguments raised in Paragraph (c), it does not rely on those arguments in resistance to the present application for leave to bring proceedings. It does so on the basis that those are proper matters to be raised by way of defence or reply, as the case may be, should leave to bring proceedings be given. I say nothing about the defendant's adoption of that course. It is free to choose. The defendant, in resistance to the present application, however, maintains the arguments raised under Paragraphs (a) and (b), and the plaintiff accepts this course.

The defendant, in the current application, disputes the applicant's attempt to rely on ss.82(6) and 86.

Turning to the facts, the plaintiff was born on 19 January 1947. He was employed by the defendant as a teacher from 1970, and was appointed on a permanent fulltime basis in 1971. He began teaching general art, photography, and graphic communication. Since 1990 additionally his duties were associated with the use of computers.

It is necessary to examine his general health and work history. He has been a non-smoker all his life, save for childhood experimentation, save for a period of two or three weeks when aged fourteen when prescribed herbal asthma cigarettes by a doctor, and save for a period of six to eight months when aged twenty during which he smoked tobacco.

He has suffered from asthma since a child, a condition disclosed to the defendant's doctors on his application for permanency in 1971.

From about 1970 to 1981 he worked at McKinnon High School. His non-class hours were mostly spent in school staffrooms: that is, in one or another of

two adjacent converted classrooms which had to accommodate 60 to 70 staff,
half of whom smoked. Windows were usually kept shut. Smoking occurred there before and after school during recesses and lunchbreaks. The rooms were smoky, often requiring the plaintiff to leave.

From 1981 to 1984 he worked at Blackburn South High School. The staffroom set-up there was similar to McKinnon. More than half the teachers smoked there. The smoke in those rooms was denser than McKinnon. More often the plaintiff had to leave those staffrooms to avoid smoke, but remained there on numerous occasions breathing smoke.

From 1984 the plaintiff worked at Coomoora Secondary College at Springvale South. There the staffroom was small and poorly ventilated, without external windows or external doors. There, seven out of nine of the staff were
heavy smokers during the early years, and later some nine out of eleven.
Teachers generally did not smoke outside the staffrooms while at work.
They smoked heavily in the staffroom. The atmosphere there at Coomoora was always thick with smoke. The plaintiff would go home at the end of the day, clothes smelling of smoke.

Between 1984 and 1985 the plaintiff made complaints to school authorities about conditions in the staffroom. An exhaust was installed, without significant effect. Smoke went up one vent and out another.

The plaintiff first noticed his respiratory capacity deteriorating in about 1987
or 1988, especially when going for exercise runs. His condition deteriorated.
He attended the Royal Melbourne Hospital. He was diagnosed with emphysema in the mid to late 1980s.

He was able to cope with his employment and life generally. It was not until 1996 or 1997 that his condition became severely debilitating and generally affected
his working capacity and day-to-day activities.

He was hospitalised for three weeks in Box Hill Hospital in March 2000, and again from 16 August 2000 to 25 August 2000, because of respiratory problems. He ceased work on 24 November 2000.

The evidence of Ivy Au, given on behalf of the defendant, is that there were six
to seven smokers in the staffroom at Coomoora, out of eight to ten people; and that it ceased to a major extent when the non-smoking policy was introduced
in mid-1989. She adds that, however, there was a great deal of tolerance shown, and smoking continued till the early or mid-1990s.

I turn to the medical evidence.

Professor Trevor Williams (report 20 September 2000), first saw the plaintiff on 20 January 2000 at the Alfred Hospital for assessment for a double lung transplant. He noted that the plaintiff was born with asthma, that his capacity
for sport was limited but improved between the ages of fourteen and thirty-five, that he played tennis and fenced (representing Australia in the latter) up until 1986. He noted the plaintiff's progressive deterioration in exercise capacity from 1990, despite medication. He noted that the plaintiff's condition had worsened since 1997 but that he had retained his capacity to work until 24 November 2000.

His diagnosis was that the plaintiff suffered moderate to severe obstructive lung disease due to asthma and bronchiectasis, with secondary pulmonary hypertension. He expressed the opinion that passive cigarette smoking may have significantly contributed both to the rate of the plaintiff's decline and also to exacerbations. He said that the effect of smoking on asthmatics seems to be to reduce responsiveness to treatment, and result in chronic fixed airway obstruction at a much earlier age than would normally occur; and smoke, as an irritant, may precipitate exacerbations and individual attacks of asthma. It can reduce the capacity to clear micro-organisms, and therefore contribute to the development of chest infections, a mechanism for further lung damage.

He expressed a prognosis that the plaintiff's airflow obstruction and markedly reduced diffusing capacity in the presence of pulmonary hypertension suggest a poor prognosis. He gave the plaintiff a 50% two-year survival without transplant, and, with transplant, a 75% to 80% two-year survival, with a 60% five-year survival.

Professor Pain, in his report dated 25 October 2000, noted that the plaintiff
had from 1971 to 1985 had problems with a chronic background of breathlessness punctuated by episodes of chest infection, and attended Royal Melbourne Hospital Thoracic Outpatient Clinic regularly, receiving medication from the hospital and his local doctor. He noted the plaintiff had been an active fencer and coach. From 1985, breathlessness on exertion had increased. Exercise tolerance had decreased materially in 1987. The plaintiff was hospitalised in March and June 2000 in the Box Hill Hospital for acute lung infections.

He noted that the plaintiff becomes breathless on slight exertion. He noted
that between 1984 and 1994 smoking in the Coomoora staffroom was extreme.
He remarked that once smoking was banned (he said in 1995) the plaintiff's condition improved considerably. In terms of diagnosis, he stated that the precise nature of the plaintiff's lung condition was not clear: he may have a form
of congenital cystic lung disease, or he may have developed a serious lung infection early in life. There is an asthmatic component to his lung condition,
but functionally it is similar to chronic obstructive bronchitis and emphysema.
He said that lung-function tests were relatively static between 1981 and 1994,
but there was considerable deterioration between 1994 and 2000.

He described the plaintiff's condition as serious. He said his condition would be aggravated by exposure to tobacco smoke, especially having an asthmatic condition. He added that previous exposure in the staffroom would have provided a basis for chronic low-grade irritation of the plaintiff's lung condition. He said that the extent to which passive smoking has affected the plaintiff

would depend on the extent of exposure. He thought it difficult to quantitate precisely the degree of deterioration which can be attributed to passive smoking over and above some deterioration expected in the plaintiff's condition even in the absence of tobacco smoke. Professor Pain had supervised the plaintiff's treatment at the Royal Melbourne Hospital over many years.

Dr Linton, on behalf of the Royal Melbourne Hospital, provided a medical history of the plaintiff that went as follows: Since the age of two, this patient had suffered problems with asthma, pneumonia, and pleurisy. He was first admitted to the Alfred Hospital for investigation of lung disease on 15 June 1966 until 25 June 1966. Dr Linton reported the plaintiff said that he had usually kept well, although he had a mild wheeze and coughing spasms. He was then diagnosed with bronchial asthma to be investigated. Investigations shows signs of emphysema and airway obstruction. Thereafter he attended the Royal Melbourne Hospital three or four times a year for some years.

It was noted that in 1994 the plaintiff complained of limited exercise tolerance. Dr Linton said that by 1999 the plaintiff had bronchiectasis, airflow obstruction and restriction. He said that on 31 March 1999 pulmonary hypertension based on his lung condition was diagnosed, and that he had deteriorated since 1994.

Mr Rosalion, a cardio-thoracic surgeon, wrote a report dated 29 January 2001.
He first saw the plaintiff on 29 January 2001, and noted that the plaintiff had
been deteriorating slowly since the late 1980s, that he had to give up sports but otherwise only noticed dyspnoea on moderate exertion, and that he had further deteriorated from 1997.

He expressed the opinion that it is well known that asthmatics who smoke tend
to have a much more rapid deterioration in their lung function. He said there is good evidence that all the damaging effects of smoking are exhibited in passive smokers. His diagnosis was that the plaintiff's primary asthmatic lung condition had been aggravated markedly by the described passive smoking exposure. He thought that the plaintiff currently had current obstructive airways disease, probable emphysema, and probably

bronchiectasis. He said that passive smoking certainly exacerbated, aggravated, and accelerated his condition. I note that Dr Maxwell, in his report of 27 November 2000, supported the latter statement.

Dr Trembath, a thoracic physician, wrote a report on 2 November 2000.
He first saw the plaintiff for the defendant on 2 November 2000. As it happened, he had seen the plaintiff over the years at the Royal Melbourne Hospital.
He noted that the plaintiff had been active in tennis, skiing, and fencing, until 1984 or a little later; that he had remained physically active with school camps as well until after 1984. He noted that the plaintiff had latterly experienced breath shortness while walking 150 metres, and with mild activity around the house.
He noted that in 1987 the plaintiff's condition worsened, and that recently
his bouts of illness had increased in duration.

Dr Trembath took a history that the plaintiff had been in the Coomoora staffroom between six to nine hours per week, experiencing bouts of protracted coughing, shortness of breath, and wheeze. He thought that the plaintiff's chronic airways disease was probably related to chronic asthma, and expressed the opinion that
a period of passive smoking while the plaintiff was employed as a teacher
in the course of his working in the staffroom, particularly from 1984, had been
a significant contributing factor in aggravating his condition. He thought that the plaintiff's employment and his capacity to work effectively has apparently been compromised by this exposure, and gave the plaintiff a poor prognosis.

He wrote a further report dated 2 November 2000. In speaking of the plaintiff's working conditions at Coomoora up till 1994, he says that it seems difficult
to escape the opinion that such exposure has been a significant contributing factor to the plaintiff's current state of disability in a very material sense. Speaking of the relative contributions to the

plaintiff’s present condition by passive smoking and by natural development of his condition, Dr Trembath says:

> "I would be more inclined to the opinion that the passive smoking
> has been a major contributing factor to his deteriorating condition
> on the basis that it was a recognised hazard for him which would have had an additive effect to other factors such as exposure to respiratory infections."

On 16 May 2001 Dr Trembath wrote a further opinion in which he said that lung function tests on the plaintiff show a gradual decline from 1982 and had become substantially worse from 1995 onwards, compared with the early 1980s. He said that the asthmatic component is the one likely to be adversely affected by exposure to passive smoking.

Dr Burdon, a thoracic physician, wrote a report dated 26 October 2000. He noted that the plaintiff had had lung infections over the years but had not been an in-patient in hospital until 2000, ten days in the month of March, and three and
a half weeks in the month of June. He expressed the opinion that the plaintiff
had bronchial asthma which had worsened over the years, and that he now had advanced airways disease.

He expressed the opinion that it is well recognised that cigarette smoking or exposure to tobacco smoke will make asthma worse, and continued exposure would result in poor asthma control and significant loss of lung function. He said that in his opinion the plaintiff’s exposure to passive cigarette smoking in the workplace had aggravated his respiratory complaint, and for this reason his employment had been a significant contributing factor to the plaintiff’s lung injury.

On the question as to whether the plaintiff’s deterioration started prior to or following 1 September 1985, he said that it was noteworthy that the plaintiff had had asthma all his life, and it is only in the last ten to fifteen years that it has become a particular problem to him.

Dr Burdon wrote a further report on 16 February 2001 in which he said that
lung function tests from the Royal Melbourne Hospital showed the plaintiff's lung function was relatively static between 1981 and 1994, followed by a considerable deterioration in the next six years.

In a further report dated 20 February 2001 (supplementary to his earlier reports after discussion) he said that deterioration of lung function occurs during periods of exposure to passive inhalation and for a little time thereafter. Any further continuing loss of lung function would not be associated with previous smoking.

On this material the defendant raises three contentions:

1. The first issue is whether the post-31 August 1985 aggravation or acceleration of the plaintiff's pre-existing lung condition renders it a "serious injury" as that expression is defined for the purposes of s.135A(6) by s.135A(19), as distinct from it already being a "serious injury" condition by that date.

It is contended, and I accept, that for the plaintiff to succeed he must show a loss of lung function which became serious, i.e. more than considerable and long-term – *Mobilio v Balliotis and Ors* [1998] 3 VR 833, after 31 August 1985, as distinct from earlier. It is put, and I accept, that this involves a comparison of his lung function pre- and post-31 August 1985, including a consideration of what was the likely course of the condition without exposure to passive smoking after that date; the exercise requires a comparison of the plaintiff's post-31 August 1985 condition with what his condition would have been after that date but for exposure: *R. J. Gilbertsons v. Skorsis* [2000] VSCA 51 . The submission is that the evidence does not show a degree of aggravation post-31 August 1985 rendering the pre-existing condition more than considerable or long-term.

The argument was put that I should prefer the evidence of Professor Pain
to that of other doctors in the case on the basis that he was the treating doctor from 1986 through to 1994, and that in the course

of his oral evidence
the professor expressed the view that 80 to 90% of the plaintiff's condition was due to underlying longstanding causes, and only 10 to 20% was related to passive smoking exposure after 31 August 1985. It was at least implied in the argument that the evidence of the other medicos did not bear on the issue of the degree of post-31 August 1985 aggravation or the degree thereof.

I reject that submission.

I have carefully studied the plaintiff's Royal Melbourne Hospital medical records.

I accept the evidence of the plaintiff as utterly truthful and accurate. Indeed,
he was challenged on neither score.

I do not find an analysis of the history of his medication to be helpful. The most that appears from that analysis is that over the years from 1966 to 2000 he has been prescribed and taken a range of medications then current for control of his asthma and a range of antibiotics then current for control of chest infections, all as they came on the market from time to time.

I find, however, the history of his complaints made on presentation to the hospital over the years and the results of his lung function tests over the years to be most helpful. In the first place they tend to support his evidence in this case, and in the second place they tend to throw light on the question as to when it was that his lung condition changed to reach such a point as to amount to a "serious injury". In my opinion it reached that point after August 1985 and before November 1997, and rapidly progressed at an accelerated rate thereafter. It had not reached the point of seriousness before 31 August 1985, notwithstanding the plaintiff's previous experiences at McKinnon at Blackburn South.

I deal first with the plaintiff's medical progress records.

Period 15 June 1966 to 22 June 1976 (inclusive)

During this period the plaintiff attended Royal Melbourne Hospital on no less than seventy-five occasions with reference to

his chest condition. Despite provisional diagnosis or final diagnosis of bronchial asthma, emphysema, chronic obstructive lung disease, pulmonary hypopnoea, bronchiectasis, intermittent asthma
and increased pleural thickening, eight reports of chest infections or pleurisy,
and complaints of coughing, wheezing, occasional loss of energy, flu,
and breathlessness, he is reported as fit, reasonably well, under control, with no special problems, not severe, chest clear, no complaints, pretty good, doing well, now better, pretty well, gradual generally better, pretty well, not bad, kept well
for fifteen years, asthma under control, asthma no real worry, lungs no problem,
no chest complaints, breathlessness not worsened, more energy, almost no cough, breathing good at present, chest has been good, chest good, not bad at moment, good on whole, generally okay, reasonable at present, chest stable, coping okay, coping pretty well, well controlled, fairly well, chest stable, asthma good. Hospital doctors wrote a letter to the Commonwealth Social Work Department
(27 February 1969) stating with reference to his condition, while this means he has periods of shortness of breath on extreme exertion, it does not really handicap him to any great extent.

During this period entries in those records tend to confirm that the plaintiff
played tennis up to four to five sets on Saturdays, engaged in fencing competition at high level, with occasional lapses during infections and the like but resuming again, played squash, went skiing, and was involved in coaching fencing.

Period 22 June 1976 through 31 August 1985 to 25 February 1986 (inclusive)

During this period the plaintiff attended Royal Melbourne Hospital on no less
than sixty-six occasions. He complained of bronchitis once, flu five times,
one infection whilst abroad, shortness of breath twice, one attack of pleurisy,
and mild wheezing and infection on two occasions. The reports

are replete with entries such as asthma stable, had best year ever, slight cough with sputum,
no cough, exercise tolerance normal, asthma stable with no infection, pretty good on whole, asthma okay, no infection, asthma and hay fever well controlled,
well no complaints, no asthma attacks for seven years, all this despite an X-ray
on 22 March 1979 indicating that he suffered from basal bullous emphysema with pleural thickening and calcification near left apex. This gave rise to a comment
on 18 October 1979 of "chronic obstructive airways disease with some bullous emphysema".

The progress reports continue, and report the complaint of bronchitis, three of the attacks of flu, the development of infection whilst abroad at about December/ January 1979/80, the complaints of shortness of breath in April and June of 1980, having stopped regular tennis due to a right-shoulder injury in March 1982,
not having got back to regular tennis by January 1984 (I note the shoulder injury). The plaintiff could still then jog two kilometres with only three to four stops.

There is a report on 7 August 1984 that the plaintiff was less active in the last three years and used to be involved in competitive sports, but he is described as generally not bad. There is a report on 3 April 1985 that he tried to resume tennis two months ago but experienced pain in the right limb. His asthma was described as stable at that point. His condition was unchanged as at 4 June 1985.

On 20 August 1985 he is reported as having been fairly good since last seen, with no severe attacks, and as still skiing. On 14 November 1985 he was described
as breathing – pretty good, although little exercise. His asthma was described
as good on 15 October 1985. On 10 December 1985 his asthma was described
as pretty good and stable. On 25 February 1986 he was described as having
no increased breathlessness, but not doing much physically apart from gardening.

The picture over this decade shows that the plaintiff maintained active sport in tennis, fencing, and skiing. But for his shoulder injury he was able to play tennis, and did so, although he had eased down competitive tennis. He skied in the United States in December/January 1982/3 at 10,000 feet. His complaints of bronchitis, flu, asthma and breathlessness were all sporadic. His asthma and chest infections were well controlled by the medications he was prescribed.

In the light of this position I think the entry of 25 February 1986 in which he
is described as not doing much physically apart from gardening, but without increased breathlessness, assumes some significance.

Period 25 February 1986 to 20 February 1996 (inclusive)

During this time the plaintiff is reported to have a dry cough but to be generally well with a clear chest on 28 October 1986, with only one recurrence in October, as at 10 February 1986. Although he complained of allergies on 7 April 1987,
as at 16 June 1987 he was playing tennis despite stable airways disease and a dry cough and wheeze notwithstanding drugs. An entry of 13 December 1988 is significant, reporting a chest infection with a cough and rattly chest coupled with shortness of breath on exertion, thick green sputum, and as afebrile at times and chest tenderness.

On 7 March 1989 he was reported as having fluctuating infections – "doesn’t seem very well". As at 6 June 1989 the status quo was maintained. A measure
of control was then achieved with drugs, but on 13 March 1990 he reported that, with some reservations, his asthma had not been a problem. On 13 November 1990 his asthma was reported as "not so good". Although on 12 February and
7 May 1991 his asthma was reported as stable, shortness of breath on strenuous exercise was noted.

On 3 September 1991 he had a six-weeks course of antibiotics, and demonstrated sputum on coughing. His asthma was brought under control again until 28 April 1992, when it was reported as not good recently, although he had been able to
go jogging. His asthma was not too bad until 8 June 1993, when

his capacity for physical activity declined. On 31 August 1993 he was reported as having had
a chest infection in July 1993, and as having been not too bad up until 5 April 1994. In a letter by Dr Trembath dated 5 April 1994 to the plaintiff's then general practitioner, he indicated that the plaintiff's asthma had been stable for some years but for the recent limited physical capacity for exercise.

Between 31 May 1994 and 28 August 1995 there are six significant entries dated 31 May 1994, 28 June 1994, 18 October 1994, 7 February 1995, 9 May 1995
and 28 August 1995. Those reports contain notes as follows: feels terrible, shortness of breath, possibly recovering from chest infection, for lung function test, feels worsening, less cough and wheeze but making only reasonable progress, not a good year, improving now, can't jog, coping reasonably well, says asthma not too good, asthma generally worsening, breathless, shortness of breath,
not now jogging, puffer working no better.

In my opinion, during this period the plaintiff's condition became serious and assumed the proportions in relation to his lung function of a "serious injury"
as defined. On 29 August 1995 Dr Trembath wrote to the plaintiff's then general practitioner, indicating that the plaintiff's condition was worsening, but that the plaintiff was reasonably happy with his progress, without respiratory distress
or wheeze, referring to stable lung function tests. In my opinion the contents of the letter are guarded, and relative to the plaintiff's then worsening condition, inability to jog, and restricted capacity for his usual sports.

The entry for 20 February 1996 records that the plaintiff's asthma was under control but some airways obstruction was noticed.

Period from 20 February 1996

On 6 August 1996 Dr Trembath wrote again to the plaintiff's general practitioner, indicating that the plaintiff was managing quite well, that his exercise tolerance was reasonable, though perhaps declining gradually. I regard this letter as similarly cautious and guarded.

Each of these letters, in the light of what follows, are shown, in my view, not to reduce the conclusion that the onset of the plaintiff's serious condition manifested in terms of his lung function shortly after August 1985.

In the period under discussion the plaintiff attended the Royal Melbourne Hospital on some twenty-three occasions. After a period of about a year of reduced stability he suffered a cyclical chest infection and was suffering from restrictive/ obstructive lung disease with worsening lung function as reported on 12 October 1997. The contents of the following sixteen entries, in my view, demonstrate
an increase in the plaintiff's rate and severity of decline of his chest condition.

On 9 December 1997 he is reported to have succumbed to a repeated chest infection. On 17 March 1998 there is a report of more shortness of breath
since August 1997, with a recurrence of infection. On 25 August 1989 there is
a report of a decline over the last two years, repeated chest infection, shortness
of breath on exertion and a wheeze, and at this point a future lung transplant
was considered.

On 3 October 1998 there is a report of bronchiectasis over the last three years
with marked deterioration. Shortness of breath with walking was noticed.
On 20 October 1998 shortness of breath was noted as worsening. It was noted on 8 February 1999 that the plaintiff had severe airflow obstruction, bronchiectasis, and had been unwell since 20 October 1998, that he was declining steadily,
had shortness of breath on inclines, and had been losing weight for two years.

On 27 April 1999 the plaintiff was noted as getting worse, with exhaustion
should he walk 200 metres, and he was referred to Dr Peveril for an angiogram. On 8 June 1999 pulmonary hypertension was noted. On the same date Professor Pain wrote to Dr Peveril,

stating "stable for most of his life, but has certainly deteriorated since 1994". The notes continue to record a decline. As at 6 October 1999 it was decided to refer him for the organisation of a lung transplant.
The note as at 8 February 2000 notes "fixed airways disease due to cystic lung disease, asthma, bronchiectasis, with pulmonary hypertension". It notes that the plaintiff cannot walk quickly or carry things or mount stairs. It notes his referral to Professor Trevor Williams at the Alfred Hospital for consideration and assessment for double lung transplant.

An analysis of the results of lung function tests is of assistance also. There are some eighteen sets of results available preceding 31 August 1985. There are some ten available since that date.

These tests, on my analysis, show considerable airways obstruction between
15 June 1966 and 14 December 1971, with some improvement between 21 March 1972 and 21 June 1988, although still with limited or moderate restriction and obstruction. Between 7 August 1990 and 14 October 1997, four out of six sets
of test results, as I read them, show or imply a new feature: "small airways obstruction or small airways disease". The results of the tests done on 31 July 1998 indicate obstruction and severe restriction, and those of 8 June 1999 indicate mixed moderate obstruction/restriction. I think the added feature of small airways disease is of some significance.

I think with the benefit of hindsight it can be clearly seen that between
25 February 1986 (the medical progress sheet entry "not doing much physically apart from gardening) and the entry of 19 October 1997 (chest infection, (cyclical) restrictive/obstructive lung disease – worsening function) the plaintiff's long-standing progressive lung condition worsened to such an extent that it took on
a new dimension of seriousness caused by an aggravation during his exposure
to passive smoking at Coomoora staffroom between 25 February 1986 and
19 October 1997. I think a comparison of the records contained in the medical progress sheets before that period tends to show that

his condition was not serious before 31 August 1985, whether it be due then to underlying pre-existing disease or previous exposure to passive smoking, but became serious thereafter. After 19 October 1997 the rate of deterioration of his then existing serious condition continued to accelerate due to his exposure to passive smoking between
26 February 1986 and 19 October 1997, at an increased rate, so as to become ultimately critical.

I think that the lung function tests tend to support that view. Up to 21 June 1988 they were fairly constant. From 7 August 1990 to 14 October 1997 they took
on an added dimension, and after that date were reported on as severe restriction.

I think the plaintiff's own evidence on the issue was important. He was capable
of high-level fencing, serious skiing, and tennis. The evidence is not clear, but
I infer that the plaintiff continued coaching fencing to somewhere around 1984-5, although he ceased to fence competitively in about 1983. He was still skiing as at 20 August 1985, but, it seems, on a reduced basis until about 1992 and on school ski camps perhaps till 1994, and he continued to play tennis to 16 June 1987, though perhaps at a reduced capacity from 24 January 1984. Furthermore, the evidence is that the plaintiff was able to continue with his work until
24 November 2000, but after 1985 with difficulty walking the distance between the staffroom and classrooms.

On the issue of the contribution of passive smoking to the aggravation of his underlying lung condition, I note that the plaintiff complained of it to his superiors at Coomoora and that he also complained of it to his doctors on 17 April 1984,
i.e. shortly after he went to Coomoora, mentioning the absence of windows, ventilation, and that there were smokers on staff.

I view the evidence of the medicos as strongly supportive of the plaintiff's case. They are unanimous that there is a causative link between passive smoking and the plaintiff's condition, at least as far as there is an asthma component. The bulk of them seem to accept that the plaintiff's underlying condition is likely to be

aggravated by the exposure to passive smoking. The bulk of them seem to accept that the degree and rate of acceleration of the plaintiff's disease will be increased the greater the exposure to passive smoking.

In my opinion, the plaintiff, whose longstanding pre-existing underlying condition was then not serious, suffered aggravation or acceleration of that condition between 26 February 1986 and 19 October 1997, which rendered his condition then and thereafter "serious" by reason of exposure during those years to passive smoking in the staffroom at Coomoora. The aggravation increased the rate of deleterious acceleration of his underlying chest condition over and above its rate of progression unaggravated. It had a serious effect on his capacity for physical activity. I think that the plaintiff's exposure as an incident of his employment at Coomoora from August 1985, considering its degree and intensity, was a very significant factor in bringing forward his need for a double lung transplant by some five to ten years according to Professor Pain (T 89 and 90), and in reducing his life expectancy from 70 to 80% five-year survival to 50% two-year survival according to Professor Williams (T 17) (CB 34). There is no question that those consequences are both serious and long-term so far as the plaintiff's lung functioning is concerned.

Turning to the second contention of the defendant to the effect that the aggravated injury which the plaintiff sustained between 26 February 1986 and 19 October 1997 was not an injury arising out, of or in the course of, or due to the nature of employment within the meaning of s.135A(1) or (2), nor "employment of that nature" within the meaning of s.135A(2), I do not think I am called upon to address those issues, having regard to the way the case was argued and my conclusions as to the defendant's main argument.

At the same time, I will say that in my opinion it is clear, and I do not think it was contested, that the aggravation of the plaintiff's condition, which I have found, arose out of or in the course of the employment of the plaintiff. I also think it falls within the expression "if employment of that nature was a significant contributing factor" within the meaning of that expression in s.135A(2). I think the words "that nature" is a reference to the whole expression preceding it in s.135A(2): "injury arising out of,

or in the course of, or due to the nature of, employment." On the other hand, if it is merely a reference to the phrase "or due to the nature
of employment", then I think the plaintiff's injury was an injury "due to the nature of employment". The "employment" of the plaintiff by the defendant includes more than merely teaching. It involves, in my opinion, provision of the place of the employment and its safety for employees, at least to the extent that those factors are within the defendant's lawful capacity to control. It was characteristic of the employment of the plaintiff at Coomoora before, but critically after,
31 August 1985, that the teachers' staffroom provided was small, ill-ventilated, without windows or doorway to the open air, housed a large number of teachers, many of whom were known to be heavy smokers and at least one who did not smoke, and which staffroom was necessarily to be used by teachers for substantial parts of each day in preparation of classes, research from books, and other duties connected with teaching: see *Accident Compensation Commission v. Botezatu* [1993] 1 VR 304.

I do not need to address the plaintiff's argument in so far as it was based on s.82(6) or s.86. I give leave to the applicant plaintiff to bring proceedings pursuant to s.135A(4)(b) of the Act.

There will be costs to the applicant plaintiff on Scale D including appropriate certificates.

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Judge W.C. Fagan