Chapter summary

The Committee considered the application of the Statements of Principles (SoPs) system, which is used to determine liability for injuries, diseases and deaths under the Military Rehabilitation and Compensation Act 2004 (MRCA) and the Veterans’ Entitlements Act 1986 (VEA). SoPs are legislative instruments that define the factors to establish a connection between a medical condition and service in the Australian Defence Force (ADF). They are determined by the Repatriation Medical Authority (RMA) according to ‘sound medical–scientific evidence’, and their aim is to provide an equitable, efficient, consistent and non-adversarial system of dealing with claims for liability. Under the Safety, Rehabilitation and Compensation Act 1988 (SRCA), in contrast, causes of medical conditions are determined on a case-by-case basis using evidence provided by a specialist medical practitioner.

Some submissions to the Review recommended that there should be discretion not to use the SoPs for claims rejected under the MRCA where claims do not meet the relevant factor(s) in the SoP. This discretion would apply to claims that were in ‘substantial compliance’ with a SoP, or where other medical evidence, such as a specialist report, supported the claim. The Committee’s view is that conferring such discretionary power on decision makers would undermine the SoP system’s strengths of consistency and adherence to expert evidential judgement.

Discrepancies between the compensation coverage of the MRCA and the SRCA led some stakeholders to argue that the liability provisions of the MRCA should be more flexible. These concerns were raised in relation to medical conditions caused by ongoing wear and tear, such as chondromalacia patellae (‘runner’s knee’), for which the acceptance rate has been much higher under the SRCA than under the MRCA. The reason for this discrepancy does appear to be the requirement for the use of SoPs under the MRCA (but not under the SRCA); however, recent changes to the SoPs for this condition are likely to resolve the issue.

Diseases that have a temporal connection with service but not a causal connection were raised in some submissions. Under the MRCA, both a causal connection and a temporal connection must be established if the claim is to succeed. As a result, conditions such as heart attacks are less likely to be accepted under the MRCA, because it is difficult to establish a causal connection with service. Heart attack is more likely to be accepted under the SRCA because of differences in the interpretation of injury and disease, and the liability provisions of that Act. While acknowledging the different outcomes between the SRCA and the MRCA, the Committee holds the view that the SoP regime under the MRCA should continue to require a disease process to have a causal relationship with service, not just a temporal relationship, before liability can be accepted for any condition that results from that disease process.

Currently, liability for an injury or disease related to a sporting activity undertaken away from the workplace is accepted under the MRCA only if that sporting activity is part of a formal training program designed by an ADF physical training instructor. In light of developing case law on the liability provisions under both the VEA and the MRCA, the Committee’s view is that the Military Rehabilitation and Compensation Commission (MRCC) should review this policy to determine whether coverage for off-duty sporting activities should be broadened. (continued)
The MRCA sets out the circumstances under which the MRCC cannot accept liability for an injury, disease or death. These circumstances, which are known as the ‘exclusion provisions’, include injury or disease resulting from a member being under the influence of alcohol, seriously breaching discipline or self-inflicting harm. Some submissions to the Review expressed concern that some of the exclusion provisions were open to the decision makers’ discretion. The Committee acknowledges this concern, but feels that the discretion within the current provisions allows each case to be assessed on its merits. The Committee also notes that there is case law clarifying the operation of exclusions, that discretion can often work in favour of the claimant, and that inappropriate application of an exclusion can be set aside on review. Although it is not aware of any case involving use of an exclusion to inappropriately deny liability for a particular injury, disease or death, the Committee considers that information technology systems should be improved to assist the MRCC in monitoring and reviewing the application of the exclusion provisions under the MRCA.

Introduction

5.1 In this chapter, the Committee considers several submissions and statements that have raised issues relating to the initial liability provisions of the Military Rehabilitation and Compensation Act 2004 (MRCA). This chapter is particularly concerned with the application of the Statement of Principles (SoP) regime under the MRCA, a system for determining medical causation issues.

5.2 The functions and the powers of the Repatriation Medical Authority (RMA), an independent statutory authority responsible for determining the SoP regime, are out of the scope of this Review. However, the Committee has examined a perceived lack of flexibility in the MRCA initial liability provisions when compared to other compensation systems, such as the Safety, Rehabilitation and Compensation Act 1988 (SRCA), and issues relating to SoPs and the MRCA have been considered in this context.

5.3 This chapter also addresses issues relating to coverage during participation in sporting activities that are not part of Australian Defence Force (ADF) training programs. It further examines assertions that the exclusions to liability, such as those relating to serious defaults and wilful acts, contained within the MRCA are too broad.

Background

5.4 The SoPs are legislative instruments, initially developed for use under the Veterans’ Entitlement Act 1986 (VEA), which set out the factors that cause certain medical conditions. SoPs are determined by the RMA according to ‘sound medical–scientific evidence’.  

5.5 SoPs alone determine what factors could cause a medical condition that is the subject of a claim. For a claim to succeed, at least one of the SoP factors must be related to service. SoPs are used in determining liability for injuries, diseases and deaths under both the VEA and the MRCA.

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1 Subsection 5AB(2) of the VEA.
2 Sections 338–339 of the MRCA.
5.6 SoPs are not used under the SRCA. Instead, medical causation issues are determined by reference to evidence provided by a specialist medical practitioner on a case-by-case basis.

5.7 Under the MRCA, there are two SoPs for each condition: one for operational service, and one for peacetime service. This is because the different types of service attract different standards of proof for determining claims.³

5.8 The more beneficial ‘beyond reasonable doubt’ standard of proof applies to claims for liability arising from operational service; that is, a claim for liability must be accepted by the Military Rehabilitation and Compensation Commission (MRCC) unless it can prove beyond reasonable doubt that the injury, disease or death does not relate to service.⁴

5.9 The ‘reasonable satisfaction’ standard of proof applies to claims for liability arising from peacetime service.⁵ To satisfy the reasonable satisfaction standard of proof, the matter contended must be demonstrated to be ‘more likely than not’.

Submissions

5.10 Ex-Service Organisation Round Table representatives supported the SoP regime, but reported that from their perspective, SoPs are not keeping up with advances in medical science; for example, new drugs and inoculations. However, the specific example of Doxycycline quoted to the Committee by the representatives had, in fact, been covered by SoPs.

5.11 Some submissions outlined a perception that greater flexibility is required when applying the SoPs under the MRCA.⁶ Other submissions argued that the liability provisions are more flexible under the SRCA than the MRCA, because of the application of the SoPs.⁷ A particular concern in many submissions is that the SoPs for some conditions do not contain a factor recognising cumulative exposure or ‘wear and tear’.⁸

5.12 Submissions recommended that the SoPs be applied with less rigour or that there be discretion not to use the SoPs in circumstances where other medical evidence supports a decision favourable to the member or former member.

5.13 An issue was also raised regarding liability for diseases that have no causal connection with service, but have a temporal connection with service. For example, ischemic heart disease that leads to a heart attack while the member is on duty.

5.14 Another issue was raised by ESO Round Table representatives who met with the Committee regarding the policy for the acceptance of injuries resulting from sporting activities not approved as part of an ADF fitness program.

³ The provisions that relate to the standard of proof applicable to claims are modelled on section 120 of the VEA.
⁴ Subsection 335(1) of the MRCA.
⁵ Subsection 335(3) of the MRCA.
⁷ Slater & Gordon Lawyers & Wyatt Attorneys.
⁸ Op cit.
5.15 Other submissions raised concerns in relation to the exclusions to liability under the MRCA. Broadly speaking, these concerns relate to a perceived lack of clarity regarding the drafting and application of the exclusion provisions.\(^9\)

**Introduction of the Statements of Principles**

5.16 In 1994, amendments to the VEA introduced SoPs, prepared by the RMA, to create a more equitable, more efficient, consistent, and less adversarial system of dealing with claims for disability and war widow(er)’s pensions. The main drivers were:

- High Court decisions in *Bushell v Repatriation Commission*\(^{10}\) and *Byrnes v Repatriation Commission*,\(^{11}\) which affected the interpretation of the beyond reasonable doubt standard of proof;
- the findings of the Australian National Audit Office (ANAO) Audit Report No. 8 1992–93 on compensation pensions to veterans and war widow(er)s, which drew attention to a lack of consistency in decision making at primary and subsequent levels, and that ‘on the interpretation of the standards of proof that has developed since 1986, applicants and veterans were being paid pensions in respect of certain disabilities which the veteran community apparently suffered at no greater rate than the community at large’; and
- the report of the Veterans’ Compensation Review Committee (the Baume Committee) in March 1994 entitled ‘A Fair Go’, which recommended the expansion of the statements at that time prepared by the Department of Veterans’ Affairs (DVA) and making them binding upon decision makers.\(^{12}\)

**Repatriation Medical Authority and the Specialist Medical Review Council**

5.17 The RMA is an independent statutory authority responsible to the Minister for Veterans’ Affairs. It consists of a panel of five practitioners eminent in their fields of medical science. Their role is to determine SoPs for any injury, disease or death that could be related to service, based on ‘sound medical–scientific evidence’, as defined in the VEA.

5.18 The Specialist Medical Review Council (SMRC) was also established in 1994, and is empowered to review the contents of a SoP or a decision by the RMA not to determine a SoP, on application from specified parties. The SMRC is established with specialists relevant to the specific condition being reviewed, whereas the RMA membership is the same for all SoPs.

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\(^{10}\) (1992) 175 CLR 408.

\(^{11}\) (1993) 177 CLR 564.

5.19 Since its inception, the RMA has determined 1,705 SoPs. Currently, 301 particular kinds of injury or disease are covered by SoPs.13

5.20 From 16 March 2007, the RMA has been able, at its discretion, to review some, rather than all, the contents of a SoP. RMA reviews that are restricted to only some of the contents of a SoP are referred to as ‘focused reviews’. This discretion is in contrast to the obligation previously imposed on the RMA to undertake a comprehensive review of all aspects of every SoP being reviewed, which often significantly delayed finalisation. More than 24 per cent of the investigations finalised during 2009–10 were focused reviews (12 of 49).14

5.21 The RMA may determine SoPs for the purposes of the VEA, the MRCA, or both Acts. However, since introduction of the MRCA, all SoPs have been determined for both Acts.

Review of the Statements of Principles

5.22 An independent Review of the SoP system was conducted in 1997 by a lawyer, Professor Dennis Pearce, and an epidemiologist, Professor D’Arcy Holman.15

5.23 Professor Pearce concluded that the system had improved equity and efficiency, and reduced the adversarial nature of the veterans’ disability pensions system. However, he found that this did not mean that in every aspect the new system is more favourable to veterans than the system it replaced. Consistency had been achieved between applicants, as substantiation no longer depended on a claimant’s capacity to find a supportive medical practitioner.

5.24 Inconsistency between DVA state offices was shown as a problem to be addressed. There was a variation in acceptance rates across state offices of 14 per cent in 1993–94. This had been reduced to 6 per cent by 1996–97, but not reduced consistently across disease groups.16

5.25 Technical analysis by Professor Holman concluded that the standard of proof applying in the veterans’ system was far less onerous than that applying in civil proceedings.17 He stated that at the margin the probability that a veteran’s disease is truly caused by eligible service could be as low as 0.8 per cent; that is, two successful claims in 1,000 are justified by true causal connection and 998 claims are not. Holman’s judgment was that there was on average a 5–10 per cent chance that a claim was related to service.

Discretionary powers to override a Statement of Principles

5.26 Several submissions recommend that, if a claim made under the MRCA is to be rejected as not meeting the SoP for a condition, then discretion should exist to accept

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14 Ibid., p. 15.
16 Following organisational changes, such data are not available beyond 2007–08. In 2007–08, the VEA acceptance rates across states ranged from 57–66 per cent, with an average of 61 per cent. Two states were 10 per cent over the average or mean acceptance rates.
17 D Pearce and D Holman, op cit., pp. 94–97.
the claim if there is ‘substantial compliance’ with a SoP, or if other medical evidence, such as a specialist report, supports the claim, as is the case under the SRCA.

5.27 One submission advocates that section 334 of the MRCA supports the MRCC in allowing a claim where there is substantial compliance with a SoP.\(^{18}\) Section 334 provides that the Commission in determining a claim is:

(a) …not bound by any rules of evidence, but may inform itself on any matter in such manner as it thinks just; and

(b) must act according to substantial justice and the substantial merits of the case without regard to legal form and technicalities …

5.28 While the Committee is of the view that this provision confirms that a decision maker ‘must act from a position of fairness and equity and honestly consider all matters relating to the claim’,\(^{19}\) the Committee does not see this provision as conferring the power to decision makers to exercise discretion in individual circumstances where there is ‘substantial compliance’ with the SoP. The SoPs are legislative instruments and are legally binding on decision makers. The system is designed such that decisions are based on a factor in the SoPs being met, and not ‘substantially met’ for reasons of consistency and adherence to expert evidential judgement.

5.29 Another submission recommends that the MRCC should be able to use section 340 of the MRCA where the resulting benefits would be greater under the SRCA than those available under the MRCA.\(^{20}\) The Repatriation Commission (under conditions set out in section 180A of the VEA) and the MRCC (under section 340 of the MRCA) may make determinations overriding a SoP in respect of a kind of injury, disease or death. However, there are a number of preconditions before this power can be exercised:

- the RMA must have declared that it does not propose to make or amend a SoP relating to a kind of injury, disease or death; and
- the Commission is of the opinion that, because a SoP is in force, or because of the decision by the RMA not to make or amend a SoP:
  - claims by members or former members of a particular class or by dependants of those members in respect of the death of those members cannot succeed; and
  - in all the circumstances of the case, those members and former members or their dependants should receive compensation.

5.30 These powers are intended to be used only in exceptional circumstances and not as a means to either usurp the RMA’s function or as a further stage of appeal of the RMA’s decision. Sound medical–scientific evidence, as defined in the VEA, is required. Determinations can only be issued in respect of classes of claimants, not individuals. The Repatriation Commission has only exercised this power once: Vietnam War veterans who were exposed to Agent Orange and who have contracted particular types of cancer (acute myeloid leukaemia, chronic myeloid leukaemia, acute lymphoid leukaemia and chronic lymphoid leukaemia).

5.31 The arguments for greater flexibility are not dissimilar to submissions made to the Pearce and Holman Review in 1997. While supporting retention of the evidence-based system using the SoPs, submitters sought the right to pursue a claim based on a

\(^{18}\) Vietnam Veterans’ Federation of Australia and KCI Lawyers.

\(^{19}\) Clause 334 of the explanatory memorandum to the Military Rehabilitation and Compensation Bill 2003.

\(^{20}\) Slater & Gordon Lawyers.
medical practitioner’s assessment of an applicant as an addition to the SoP-based process. Professor Pearce responded as follows:

6.6 [I]t was this issue of balancing competing medical opinions that drove the changes made in 1994. The difficulty of a non-medically qualified tribunal choosing between competing opinions with what were perceived to be consequential inconsistencies between like cases was a major factor in the seeking of a new approach to the determination of causation. To wed this former system onto the SoP system would be to return to the position that previously existed as it would allow a person who could not satisfy a SoP to then engage in the pursuit of medical opinions that, by definition, did not accord with sound medical-scientific evidence.21

5.32 The Committee considers Professor Pearce’s response to be still relevant.

Acceptance rates between the Safety, Rehabilitation and Compensation Act and the Military Rehabilitation and Compensation Act

5.33 Submissions to the Review argue that the MRCA liability provisions have brought about unintended limitations on compensation coverage, as demonstrated by the discrepancy in acceptance rates between the SRCA and the MRCA in claims for conditions caused by ongoing wear and tear over a significant period.22

5.34 Concern about the acceptance rate of chondromalacia patellae (also known as CMP, patellofemoral pain syndrome and runner’s knee) had previously been raised with DVA, and has prompted the Department to commission a research study to review and compare CMP claims determined under the MRCA and the SRCA. The study was conducted from April 2008 to June 2009, and examined in detail 249 SRCA and 199 MRCA claims for the 2006 and 2007 calendar years. Of interest are the following findings:

• there was a stark difference in acceptance rates, at 97.6 per cent for SRCA claims and 57.8 per cent for MRCA claims;

• no reasons were found for the difference in acceptance rates (e.g. age of client, type of service), other than the requirement for the use of SoPs under the MRCA; and

• when the authors re-examined SRCA claims and artificially applied the SoPs to them, the SRCA acceptance rate fell to a similar level to that for MRCA claims.

5.35 The study confirmed that the MRCA provisions were being applied as intended; that is, to ensure that ‘sound medical–scientific evidence’ is used in decision making.

5.36 The RMA has recently completed a focused review of the SoPs for CMP. The review was gazetted in April 2009 and public submissions closed on 31 July 2009. The RMA finalised its deliberations of the review of the contents of the SoPs concerning CMP on 4 August 2010. It decided to revoke Instrument Nos. 33 and 34 of 2001, and to determine new SoPs that came into effect on 1 September 2010. Both SoPs for CMP now contain factors specifying running or jogging to be a cause of CMP, whereas previously only the operational service SoP contained a running factor. The new peacetime SoP factor reads as follows:

… running or jogging on average at least 20 kilometres per week for at least the one month before the clinical onset of chondromalacia patella …

21 D Pearce and D Holman, ibid., p.22.
22 Slater & Gordon Lawyers.
5.37 The Committee notes that concerns regarding liability for CMP are likely to have been addressed by the inclusion of this new factor.

5.38 The Committee also noted that there are already mechanisms within the regime for the review of SoPs through the RMA and the SMRC. The review of SoPs has been improved by the amendments in 2007 allowing focused reviews by the RMA — effectively the capacity to review single factors for conditions covered by the SoPs.

5.39 The Committee discussed issues in relation to emerging diseases or exposures not yet covered by the peer-reviewed scientific literature. The Committee considered some past developments, for example, issues affecting the F-111 Deseal/Reseal cohort and the British nuclear test participants, but drew no conclusion that SoPs were an unsuitable approach. The importance of continuing ADF health care for serving members and non-liability treatment provisions for malignancies, psychiatric disorders and undiagnosed illnesses was noted, as was the fact that the ADF and DVA have worked together on setting up health studies for major deployments and longitudinal studies of ADF members’ health and exposures.

**Difficulties with the ‘occurrence’ test under the Military Rehabilitation and Compensation Act**

5.40 The MRCA contains several ‘heads of liability’ — that is, legislative tests that must be met to establish the relevant connection between a claimed injury, disease or death, and service. Only one head of liability needs to be satisfied for a condition to be determined to be related to service. One head of liability under the MRCA, known as the ‘occurrence test’, provides that:

> For the purposes of this Act, an injury sustained, or a disease contracted, by a person is a service injury or a service disease if one or more of the following apply:

(a) the injury or disease resulted from an occurrence that happened while the person was a member rendering defence service …

5.41 While the occurrence test in the MRCA is a temporal test, it also contains a causal element. The temporal element is that the occurrence must have happened while the person was rendering eligible service. The causal element is that the injury, disease or death must have resulted from an occurrence.

5.42 In *Repatriation Commission v Law*, the Full Federal Court held that an ‘occurrence’ is something that occurs, happens, or takes place. It must be something different from ordinary day-to-day events. The Court held that contraction of a disease, or a disease process, are not occurrences.

5.43 For conditions covered by a SoP, the SoP factor must incorporate the relevant occurrence that is said to have caused the injury, disease, or death.

5.44 Take for example, a soldier who is on duty in Iraq and trips heavily as a consequence of being jostled up the stairs. He lands heavily on his right knee, which remains painful for several days. Within a few weeks he develops CMP in that knee.

5.45 The heavy fall is an occurrence that meets the requirements of the CMP SoP for warlike or non-warlike service: ‘suffering direct trauma to the patella of the affected knee within the six months immediately before the clinical onset of CMP’. Therefore, it

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can be said that the CMP resulted from an occurrence that happened while rendering defence service.

5.46 However, if the occurrence is not represented in the SoP, or does not meet the specific requirements of the relevant factor, the occurrence test cannot be satisfied. The claim may still succeed under another head of liability — for example, the ‘arising out of’ test or the ‘but for’ test.

5.47 An issue has been raised in one submission in relation to the ‘occurrence’ head of liability under the MRCA and the application of the SoPs. The submission states:

2.3 The issue of certain diseases, for example coronary vascular diseases, causing myocardial or cerebral infarction (i.e. heart attack or stroke) and its relationship to service is highly contentious.

2.4 The AAT, Federal and High Court have finally determined when these ‘diseases’ are aggravated in certain circumstances then they should be considered ‘injuries’ for which liability is accepted under the SRCA.

2.5 In a large number of cases if the ADF member suffered a heart attack or stroke for example, due to the ‘temporary departure’ from their normal physiological state because of exercise, workplace stressors or whilst performing a physical activity DVA have denied liability. The basis of the denial was in effect, that the person's ‘normal physiological state’ may not have been aggravated by their service that subsequently caused the heart attack or stroke.

2.6 Ultimately the High Court affirmed the Federal Court and the AAT's approach whereby if these conditions are aggravated in the workplace i.e. heart attack and cerebral strokes they should be accepted as injuries. 25

5.48 For example, the SoP for ischaemic heart disease contains a number of factors, some of which might be described as an occurrence. Nevertheless, it is commonly contended that a heart attack has been caused by a person suffering hypertension or some other underlying disease (the SoP factor is as follows: ‘having hypertension before clinical onset of the ischaemic heart disease’).

5.49 Because suffering hypertension is not an occurrence, the claimant must instead try to establish a causal connection between the ischaemic heart disease or hypertension and his or her service under one of the other heads of liability, or rely on another SoP factor. Establishing this causal connection with service is not easy, particularly given that smoking contentions have been excluded in the MRCA.

5.50 The result of all this is that a claimant is unlikely to have a death from heart attack or similar accepted under the MRCA simply because that heart attack occurred while the member was rendering defence service. In other words, it is not enough that the member suffered the heart attack while on duty instead of at home — the member’s duties must have caused the heart attack.

5.51 The position under the SRCA is quite different due to a number of Federal Court and High Court decisions that have impacted on the way in which determining authorities are required to interpret the definition of injury and disease, and the liability provisions of that Act. In Zickar v MGH Plastic Industries Pty Ltd,26 an internal rupture or break of the blood vessels within the heart during a heart attack was considered to be an injury (as opposed to a disease). This meant that the temporal test for injury within the SRCA (as opposed to the causal test for disease) could be used to accept liability for that heart attack.

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25 Vietnam Veterans’ Federation of Australia/KCI Lawyers.
Therefore, death from heart attack while at work will commonly be accepted under the SRCA, whereas a similar death while on duty may not be accepted under the MRCA due to the application of the SoPs and the occurrence requirement.

The Committee acknowledges the different outcomes between the SRCA and the MRCA. However, the Committee formed the view that the status quo under the MRCA should be maintained. The Committee supports the SoP regime under the MRCA, which requires a disease process to have a causal relationship with service, not just a temporal relationship, before liability can be accepted for any condition that results from that disease process. The Committee notes that the VEA has operated under the same legislative rules for operational service for a number of years, generally without issue or concern.

Injuries sustained by members while rendering defence service

Committee members have identified a potential issue, not necessarily related to the SoP system, which is particularly relevant to injuries sustained by members at the time they are rendering defence service.

In the matter of Eagle and Military Rehabilitation and Compensation Commission, the Tribunal considered the applicant’s evidence that he had damaged a tooth while participating in physical training in the course of his defence service.

The Tribunal found that under the MRCA, evidence was required regarding a causal relationship between an occurrence and the injury to the tooth. The applicant could not recall a particular occurrence that caused his damaged tooth, and only that his tooth was not damaged before training but was damaged afterwards.

Despite the Tribunal being satisfied, on the basis of the applicant’s evidence, that he sustained the injury while participating in the training run in the course of his defence service, it found that the injury was not service related, because there was no evidence of an occurrence that resulted in the damaged tooth.

In essence, under the MRCA, it is not enough that the person was rendering defence service at the time of the injury, but it is a requirement to identify an occurrence that caused the injury. This is very different from the ‘in the course of employment’ test that applies under the SRCA, which simply requires that the injury was sustained in the course of defence service, with no causal requirement.

The Committee believes that this single Tribunal matter does not warrant change in itself. The Committee again notes that the VEA has operated under the same legislative rules for operational service for a number of years, generally without issue or concern.

Liability and personal fitness regimes

ESO Round Table representatives expressed concern regarding the current MRCC policy that a claimant must demonstrate that an off-duty sporting activity is part of a formal training program designed by an ADF Physical Training Instructor before liability for an injury or disease related to that sporting activity can be accepted under the MRCA.

5.61 The ADF requires its members to meet defined physical fitness standards as part of the conditions of service. Compulsory physical training and compulsory participation in some ADF-organised sporting events are conditions of service that apply to most members. These are on-duty activities. Unlike injuries sustained or diseases contracted participating in ‘civilian sport’, there is no requirement on the member to prove they were approved to participate in ADF-organised sporting events.

5.62 However, fitness activities are also often voluntary (in respect to each individual case), undertaken away from the place of work and while the member is off duty. In such cases, the injury or disease can be seen to ‘arise out of’ the rendering of defence service. Liability for such injuries or diseases may be accepted where the activity was conducted in accordance with the Defence Instruction (General) in relation to the ADF Policy on Sport (DI(G) PERS 14-2).

5.63 DI(G) PERS 14-2, dated 9 June 2005, ‘Australian Defence Force (ADF) Policy on Sport’ states that:

Defence personnel who are authorised to participate in sport within the terms of this instruction are authorised as ‘on duty’, subject to any applicable exclusions. It should be noted, however, that the authorisation of ‘on duty’ status does not guarantee compensation coverage.

5.64 The DI(G) covers:

• programmed sport — sport conducted during the base or unit’s programmed training;
• local sport — ADF-sponsored sport conducted in the local region;
• inter-service sport — ADF sport at any level but between two of the services; and
• combined service sport — at state, national or international level with members from at least two of the services.

5.65 Where the member has been selected to represent the ADF in a general community (civilian) sporting event or tournament or similar, any injuries received by that member as a consequence may also be compensable. Note that a nexus with service may also exist should the ADF either ‘sponsor’ the member by providing equipment or similar, or authorises the member to be identified as representing the service in a community event.

5.66 The DI(G) also accredits a number of ADF sports associations. Sports played under the terms of the relevant ADF sports association are accepted as approved sports for compensation purposes.

5.67 Sports that are not directly approved by the DI(G) may, however, still come under the coverage of the MRCA, if they meet the criteria already listed; that is:

• approved for that individual member in routine orders or equivalent; or
• clear and identifiable connection with a fitness program where that activity clearly promotes fitness (e.g. orienteering, gym work, jogging or swimming) or improves skills relevant to the member’s Commonwealth employment (e.g. rifle shooting).

5.68 The ADF member’s duty to maintain physical fitness means that he or she may claim that a number of miscellaneous activities, such as solo jogging or body building, are responses to ADF fitness requirements, even though these activities were conducted ‘off base’, without supervision and were not part of approved civilian sport.
5.69 For the purposes of the VEA, in *Roncevich v Repatriation Commission*,\(^{28}\) the High Court stated that ‘rendering defence service’ requires the person to be on duty or be doing something required, authorised, or expected to be done in connection with, or incidental to, the person’s duties. Because the MRCA liability provisions are based on the VEA, *Roncevich* remains applicable.

5.70 This case law has led to a wide interpretation of the phrase ‘rendering defence service’. In light of this case law, the current policy on liability and personal fitness regimes may be too restrictive and should be relaxed. The MRCC should review its policy and revisit its exclusion on liability for injuries sustained or diseases contracted as a result of sporting activities that are not part of a formal training program designed by an ADF Physical Training Instructor.

**Provisions excluding the acceptance of liability**

5.71 The MRCA sets out the circumstances where the MRCC cannot accept liability for an injury, disease or death, known as the ‘exclusion provisions’. The exclusion provisions apply even if the claim otherwise satisfies the heads of liability and the relevant SoPs.

5.72 The MRCC is excluded from accepting liability if the injury or disease (but not death):\(^{29}\)

- resulted from a member’s serious default or wilful act, including being under the influence of the alcohol or the drug (not taken as prescribed);
- arose from the injury or disease arose from a serious breach of discipline committed by a member;
- was intentionally self-inflicted by a member;\(^{30}\)
- resulted from reasonable and appropriate counselling in relation to member’s performance; or
- resulted from a member’s failure to obtain a promotion, transfer or other benefit.\(^{31}\)

5.73 The exclusions listed above do not apply if the injury or disease results in serious and permanent impairment.

5.74 Liability is also excluded were a person has made a wilful and false representation, in connection with his or her defence service, that he or she did not suffer, or had not previously suffered, from an injury or disease.\(^{32}\) Unlike the exclusions already mentioned above, this exclusion also applies to claims relating to the death or serious impairment of a member or former member.

5.75 Liability exclusions also apply in relation to conditions, including death, resulting from accidents that occur while a member was travelling on a journey that was, for reasons unconnected with ADF service, delayed, indirect, or substantially interrupted.\(^{33}\)

\(^{28}\) *(2005) 222 CLR 115.*

\(^{29}\) Sections 32-33 of the MRCA.

\(^{30}\) Section 32 of the MRCA.

\(^{31}\) Section 33 of the MRCA.

\(^{32}\) Section 34 of the MRCA.

\(^{33}\) Section 35 of the MRCA.
Lastly, liability is excluded if a condition, including death and serious impairment, resulted only from the person’s use of tobacco products. Therefore, the factors in the SoPs relevant to tobacco use are redundant in the MRCA. Similar exclusions were made in subsections 8(6) and 9(7) of the VEA and have applied since 31 December 1997.

Submissions relating to liability exclusions

Representatives of the ESO Round Table and several submissions to the Review expressed concern that the phrase ‘under the influence of alcohol’ is not defined in the MRCA and is open to the decision makers’ discretion. One submission recommends that ‘being under the influence of alcohol’ be replaced by words specifying an amount of alcohol to be permitted before a serious default is established.

Another submission argues that anomalies may arise from the application of the exclusions relating to a serious breach of discipline. This submission also expresses concern regarding the discretion relating to what constitutes a ‘delay’ for the purposes of the travel exclusion.

While the Committee acknowledges concerns raised in the submissions, it has not been made aware of any specific examples of an exclusion being used inappropriately to deny liability for a particular injury, disease or death. The provisions of the MRCA have been modelled on similar provisions that have been applied under the VEA and the SRCA for some time, albeit with some modification. There is a significant amount of case law governing the discretionary nature of their application by the MRCC and its delegates.

An inappropriate use of a decision maker’s discretion can, of course, be reviewed by either internal reconsideration or the VRB and the AAT.

Furthermore, discretion can result in a flexibility that often works in favour of the claimant. To make the provisions more prescriptive — for example, deeming a specific blood alcohol content to be over the limit — could, of course, result in detriment to claimants in some circumstances and may also be impractical (as blood alcohol level may not be known). The Committee feels that the discretion within the current provisions provides for each case to be assessed on its merits.

However, because the application of the exclusion provisions is not recorded on the MRCA system, detailed analysis is difficult. The Committee feels that information technology (IT) systems should be improved to assist the MRCC in monitoring and reviewing the application of the exclusion provisions.

Conclusions

In this chapter, the Committee has considered submissions relating to the initial liability provisions of the MRCA with a focus on the SoP system.

34 Section 36 of the MRCA.
37 Vietnam Veterans’ Federation of Australia and KCI Lawyers.
38 Vietnam Veterans’ Federation of Australia and KCI Lawyers.
5.84 The Committee is of the view that there should not be scope for decision makers to exercise discretion in individual circumstances where there is ‘substantial compliance’ with a SoP, as this would undermine a system based on sound medical–scientific evidence.

5.85 Furthermore, the Committee recognised that the powers conferred upon the MRCC to make determinations outside the SoP system are intended to be used only in exceptional circumstances and not as a means to usurp the function of the RMA. The same is true for similar powers conferred upon the Repatriation Commission under the VEA.

5.86 The Committee notes that there are other more appropriate mechanisms within the regime for review of SoPs through the RMA and the SMRC, and recognises that these mechanisms have been strengthened by the amendments in 2007, allowing the RMA to review single factors in the SoPs rather than the whole of a SoP.

5.87 The Committee acknowledges the different outcomes between the SRCA and the MRCA in relation to disease processes with a temporal connection to service. However, the Committee believes it is appropriate that the SoP regime under the MRCA requires a disease process to be causally related to service for liability to be accepted for conditions resulting from that disease process. This has been the Repatriation Commission’s position under the VEA for many years.

5.88 The Committee concludes that the MRCC should review its policy in relation to off-duty personal fitness regimes, and consider whether, in light of relevant case law, it is appropriate to deny liability for injuries sustained or diseases contracted as a result of sporting activities that are not part of a formal training program designed by an ADF Physical Training Instructor.

5.89 Lastly, the Committee has examined concerns relating to the exclusions from liability in the MRCA. The Committee notes that; there is case law clarifying the operation of exclusions; discretion can often work in favour of the claimant; and inappropriate application of an exclusion can be set aside on review. No specific examples of exclusions being applied by decision makers inappropriately were brought to the attention of the Committee; however, the Committee feels that IT systems should be improved to assist the MRCC in monitoring and reviewing the application of the exclusion provisions.

**Recommendations**

The Committee recommends that:

5.1 there should be no change to the current Statements of Principles regime;

5.2 the Military Rehabilitation and Compensation Commission (MRCC) should monitor the situation in relation to injuries sustained by members at the time they are rendering defence service to ensure that the Military Rehabilitation and Compensation 2004 (MRCA) liability provisions are operating fairly;

5.3 the MRCC should review its policy in relation to off-duty personal fitness regimes, and consider whether, in light of relevant case law, it is appropriate to deny liability for injuries sustained or diseases contracted as a result of sporting activities that are not part of a formal training program designed by an Australian Defence Force Physical Training Instructor; and

5.4 information technology systems should be improved to monitor and report information relating to the application of the exclusion provisions under the MRCA.