Determination Number: AA 258/03
File Number: AEA 705/02

*Under the Employment Relations Act 2000*

**BEFORE THE EMPLOYMENT RELATIONS AUTHORITY**
**AUCKLAND OFFICE**

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| **BETWEEN** | Robyn Robertson (Applicant) |
| **AND** | Waikato District Health Board (Respondent) |
| **REPRESENTATIVES** | Oliver Collette-Moxon, for Applicant<br>Emma Huston, for Respondent |
| **MEMBER OF AUTHORITY** | Y S Oldfield |
| **INTERVIEW** | 4 December 2003 |
| **INVESTIGATION MEETINGS** | 25 February 2003<br>26 February 2003<br>27 February 2003 |
| **FINAL SUBMISSIONS** | 5 March, 18 March 2003 |
| **CONSIDERATION OF "**Report of a Ministerial Inquiry into the Management of Certain Hazardous Substances in Workplaces, July 2003." | July 2003 |
| **DATE OF DETERMINATION** | 25 August 2003 |

## DETERMINATION OF THE AUTHORITY

### Employment Relationship Problem

The applicant first lodged this matter with the Authority in July 2002. It was expressed to be in two parts. The first was a disadvantage action founded on alleged breaches of implied and express terms of the contract of employment, and of statutory duties pursuant to the Health and Safety in Employment Act. These breaches were said to have caused Mrs Robertson personal injury. The second aspect of the problem was a claim of unjustified dismissal, arising out of the termination of Mrs Robertson's employment in June 2002. The central issue there was whether the respondent had made sufficient and appropriate attempts to re-deploy the applicant to a safe and suitable position, and had managed the redeployment process in a fair and reasonable way.

The respondent provided a full statement in reply with a number of relevant attachments. This had been prepared and lodged before the respondent instructed Counsel. It was perhaps partly due to this that it was very wide-ranging however a further reason, in my view, was that the particulars giving rise to each aspect of the problem were not sufficiently specific to put the respondent properly on notice of the precise basis of Mrs Robertson's claims.

Because of these concerns and because of my own wish to conduct a focussed and economical investigation, I requested further particulars from the applicant. In all I was to receive from Counsel for the applicant an amended statement of problem (26 September 2002,) two sets of further particulars (22 October 2002 and 8 November 2002) and a memorandum (12 December 2002) which accompanied expert evidence and also amounted to further particulars.

These further particulars have clarified and modified the applicant's claim and shaped the course of the investigation. This is demonstrated by the series of Minutes issued as the investigation has progressed and which are attached.

As amended, the remedies sought by the applicant are:

- Lost earnings during her extended sick leave, being the difference between the earnings related compensation paid to her during that time and her former salary;

- $25,000.00 for hurt and humiliation arising out of her disadvantage claim;

- $20,000.00 compensation for distress arising out of the respondent's failure to conduct redeployment negotiations;

- $20,000.00 compensation for distress arising out of unjustified dismissal.

Partly because the applicant's claim remained unclear for some time, this has also become the most time consuming of any investigation I have conducted pursuant to the Employment Relations Act 2000. I have been presented with a large volume of documentary evidence and have conducted additional inquiries at my own initiative. In so doing I have perused:

- Mrs Robertson's case notes and other records from Injury Management New Zealand;
- The OSH files and reports on her case;
- The collective employment agreements in force at the relevant times (*Health Waikato Limited Combined Support Services Staff Collective Employment Contract 1 March 1999-28 February 2001* and *Waikato District Health Board Allied Health, Clerical , Technical and Related Employees Collective Agreement 5 March 2001-30 November 2002*.
- The Health and Safety policies of the respondent, Waikato District Health Board (WDHB;)
- The respondent's redeployment procedures;
- All relevant notes taken by union and management personnel at meetings to discuss her redeployment;
- Her medical records;
- Successive editions of the respondents in-house newsletter '*Insider;*'
- The *Report of a Ministerial Inquiry into the Management of Certain Hazardous Substances in Workplaces 2003.*

I have heard from the following witnesses:

- Mrs Robyn Robertson, applicant;
- Mr Clive Robertson, her husband;
- Ms Lynn Kiddie, union delegate;
- Ms Marian Rillstone, union organiser;
- Mr Murray Armstrong, radiographer;

- Dr Leicester Hodge, dermatologist;
- Dr Marius Rademaker, dermatologist;
- Dr Geraint Emrys, occupational health physician;
- Ms Ruth Ross, Human Resources Manager;
- Ms Marie Fullerton, Health and Safety Adviser and then Manager, Health and Safety Service, WDHB.
- Mr Michael Webb, manager, radiology department, WDHB.

A statement was also provided by Ms Sandy McLennan of Injury Management New Zealand but I did not consider it necessary to interview this witness.

Finally I conducted a site visit of the Radiology Department and the Hocken Building at Waikato Hospital.

Due to its specialised nature, much of the material has required painstaking consideration. However, as the matter has progressed and the employment problem has unfolded it has become clear that not all of it is critical to the determination of the problem as finally expressed.

A considerable period has now elapsed since receipt of final submissions. Being mindful of this, I have attempted to approach the writing of this determination in as economical a fashion as possible. It will address the applicant's claims in what I understand to be their final form, as indicated in closing submissions. I will summarise only that evidence which bears directly on the outcome of the case.

**Chronology of Key Events**

1. Mrs Robertson started work at the Waikato District Health Board ('WDHB') in 1989. Her position was clerical in nature and was located in the respondent's radiology department. Collating x-rays (most of which were newly developed) formed the major part of her work.

2. From **August 1989** onwards, Mrs Robertson's work involved handling newly developed X-rays, fresh from the processor. It is her evidence that they:

   "would usually be damp with chemicals and have a chemical smell."

3. Over the next ten years, Mrs Robertson's duties changed from time to time, but usually involved handling X-rays, sometimes fresh from processing. For approximately one year from September 1989 she dealt with older X-rays which were stored in paper packets (since phased out) and she reports that on occasions chemicals would have leaked into the paper, making it smell strongly. Sometimes, she said, there was also a fine white powder on the surface of the films, which she could not help but breath in.

4. Due to the length of time which has elapsed since September 1989 it was not possible to obtain any further information about the nature of either the seepage or the powder to which Mrs Robertson refers here.

5. Mrs Robertson also noted in her evidence the following incidents which took place during this ten year period:

   - In **November 1993** there was seepage of glutaraldehyde in the Ultrasound Department. Mrs Robertson was seen at the time by the Occupational Health and Safety Department of

WDHB for a sore throat, cough and green sputum. She was given antibiotics, which appeared to resolve her symptoms.

- In **Mid 1994** there was leakage of strong smelling fumes from the X-ray processor; at other times there were lower levels of fumes.

- In **Mid-1996** renovations of the department caused fibreglass dust. The carpenters used masks but WDHB staff did not.

- **Late 1996 and early 1997** hard nodules appeared under the skin on two of Mrs Robertson's fingers.

6. The events which appear to have a direct connection to the development of Mrs Robertson's on-going symptoms began on **10 September 1999** when she formally reported to the respondent that some x-rays she had handled were covered in strong smelling liquid. It was later determined that the liquid was most probably water, which may have reacted with the film. Mrs Robertson told me in her evidence that her hands became red and blistered on the palms as a result. However she did not include this information in her report of the incident.

7. Following this incident the respondent formally reminded all staff of the importance of storing X-rays correctly and ensuring that they did not come into contact with water.

8. A similar incident occurred on **18 November 1999.** Mrs Robertson completed an accident/incident form but did not fully set out the nature of the adverse reaction suffered. Under 'Staff Health and Safety- Injury' she recorded 'chemical effect' but gave no other information as to the nature or location of the injury.

9. A further incident of a similar nature occurred on **25 November**. A further form was completed and this time, the applicant provided more details of her injury.

10. The next day one of the respondent's health and safety advisors contacted the applicant. Marie Fullerton of the respondent's health and safety department followed up this contact. Ms Fullerton informed the applicant of the respondent's "skin policy" and told her that the next step under this policy was for Mrs Robertson to see her GP about the problem. She also instructed Mrs Robertson to wear cotton gloves when touching films. (Mrs Robertson's recollection is that she may have already started doing so on her own initiative, although she says that some of the gloves she began using were latex.)

11. The respondent's skin policy covers situations where an employee believes they have a work-related skin problem. Under the skin policy employees with skin conditions are provided with, and required to wear, appropriate personal protective equipment. To ensure the problem is properly identified, the policy also requires employees to obtain a diagnosis from their GP and, if necessary, a referral to a dermatologist.

12. WDHB employs a specialist occupational physician, Dr Geraint Emrys, one day per week to provide expert medical advice on health and safety issues. Dr Emrys did not become involved with Mrs Robertson's case until early 2000, but he told me that after reviewing her file he was satisfied that there had been no reason to advise Mrs Robertson to wear gloves before November 1999. He told me:

"The risk of someone developing a reaction to x-ray film is negligible. For this reason, the wearing of gloves by people who handle x-ray films- whether they be doctors, radiologists, technicians or clerical staff- is certainly not

standard practice, and in my opinion nor should it be. The reaction Robyn suffered is unusual, and hers is an atypical case.

A person would only be advised to wear gloves if he or she developed some sort of reaction. That is how contact dermatitis is prevented- by eliminating contact."

13. Meanwhile, during the latter part of 1999 the radiology department was undergoing restructuring. Mrs Robertson was retained in her original role, although this was not her preferred option. She told the Authority that she believes she also raised the matter of her health problems with management of the X-ray department at this time. Mr Webb, the manager of the department, cannot recall her raising this and doubts that she could have because his recollection is that the consultation phase of the restructure was over by the time Mrs Robertson's problems had become apparent.

14. Unfortunately there seems to be no documentary evidence available to resolve this conflict, and given the time that has elapsed, I do not consider the recall of either witness to be reliable on this point. I do not make any finding on it.

15. On **1 December 1999** Mrs Robertson's right hand again became red and itchy (almost painful) following accidental contact with an X-ray. She went to the accident and medical centre where she was given cortisone cream and again advised to wear gloves.

16. **8 December 1999** Ms Fullerton made a follow-up call to Mrs Robertson and discussed the most recent incident. She advised Mrs Robertson that it was now essential that she obtain a referral to a dermatologist in accordance with the respondent's "skin policy."

17. Mrs Robertson saw Dr Hasan (her G.P.) twice during November-December 1999. On the second occasion he referred her to Dr Rademaker a specialist dermatologist at Waikato Hospital and Honorary Associate Professor at Auckland Medical School. Dr Hasan's referral letter listed contact dermatitis as his diagnosis. As it happened, this was Dr Rademaker's sub-speciality. An appointment was made for Mrs Robertson at the first available opportunity, **March 2000**.

18. After seeing Mrs Robertson, Dr Rademaker expressed a view that her history was not consistent with an allergic contact dermatitis. Nonetheless he noted:

"It is important that we do exclude allergic contact dermatitis by patch testing"

19. Patch testing is the accepted standard investigation for allergic contact dermatitis. Dr Rademaker therefore arranged to 'patch test' Mrs Robertson in **May 2000**. In the meantime, he endorsed the continued use of the gloves and barrier cream previously recommended by the respondent.

20. On **18 April 2000,** after picking up a pile of X-ray films on her desk the applicant experienced what she described as an allergic reaction:

"Both of my forearms started burning on the insides, which moved to an itching feeling further around. I had a hoarse voice and the roof of my mouth tingled along with my lips. My lips also felt swollen and I had trouble swallowing. It felt like I had a lump stuck in my throat and a tight chest."

21. Mrs Robertson's manager sent her down to Accident and Emergency where she was treated with phenergan and sent home. The incident form does not record any respiratory symptoms.

22. At this point, Ms Robertson's appointment with the dermatologist was fast approaching. Because of this, and because appropriate control measures (gloves, barrier cream and regular hand washing) were in place, no further action was taken.

23. Dr Rademaker completed Mrs Robertson's patch tests on **15 May 2000.** He reported (somewhat to his surprise, because her history was not suggestive of allergic contact dermatitis) that she had positive reactions to metol and ammonium persulphate, products used in processing and developing of photographic film, although not in use in the radiology department at WDHB at that time. These compounds are also used in hair dyes and bleaches, and in electroplating.

24. He noted in his report:

> "Treatment of contact allergic dermatitis involves separation of the patient from the allergen which give rise to the dermatosis. Either the allergens can be removed from the workplace environment or work practises altered such that the patient doesn't come into contact with them. Alternatively the patient can continue working in the workplace environment and tolerate the dermatitis. Clearly the first is the most desirable outcome, but it is sometimes not achievable.

25. Dr Rademaker gave Mrs Robertson an open appointment to see him again if her dermatitis continued to be a problem.

26. Dr Emrys, WDHB specialist occupational physician, became involved in the management of Mrs Robertson's case at around this time.

27. On **4 July**, after receiving Dr Rademaker's report, and again on **14 July**, Dr Emrys contacted Kodak (the suppliers of the photographic chemicals used at WDHB) to inquire whether the compound identified by Dr Rademaker's test was likely to be present on Kodak's processed film. (Or, alternatively, if other substances of a similar chemical nature could be responsible for producing the same reaction.) Kodak responded (**31 July**) by saying that it was not aware of any such chemicals being present on developed film.

28. Between **21 July 2000** and **15 August 2000** the applicant took sick leave as a result of planned knee surgery.

29. On **15 August 2000** Dr Emrys performed a clinical review of the applicant's case. He advised that she continue with the control measures that were in place, as well as using cotton gloves and carrying a supply of phenergan.

30. Also at some time in **August 2000**, Mrs Robertson's problems came to the attention of Ms Lyn Kiddie, who was a delegate for Mrs Robinson's union, the Public Service Association. From that time onwards, in that capacity, Ms Kiddie provided support to Mrs Robertson. The case was also brought to the attention of the local PSA organiser at around this time.

31. Unfortunately, on **21 August** the applicant suffered another severe reaction when one of her protective gloves ripped whilst she was handling X-rays. This time, in addition to burning, itching and redness of the skin, she also experienced a tight chest and cough, with headache and neck stiffness.

32. Dr Emrys saw her the next day and in light of this new development, he and the applicant agreed that she could no longer continue to work in Radiology. The applicant took leave commencing immediately.

33. At the investigation meeting, Dr Emrys told me that he believed then that Mrs Robertson had been removed from the radiology department at the correct time, and continued to believe this now, with the benefit of hindsight.

34. One of the most vexed issues of Mrs Robertson's has been the puzzle as to what it was on the surface of X-rays that was causing her problems. Films were finished with an inert gelatin-like surface akin to that of a water based paint, and should not, in theory have posed a problem.

35. I heard evidence on this point from a Mr Armstrong, a senior and experienced radiographer in the X-ray department at WDHB. He told me that the X-ray processors were poorly maintained and did not function as well as they should. He also told me:

> "It is conceivable but unlikely that Mrs Robertson would have handled wet film. By wet, I mean moist to the touch. As Dr Emrys pointed out, the films were left to dry on a bench. If there was ever any water left from rinsing, it would almost certainly have dried by the time Mrs Robertson came to handle them.
>
> However, the situation is different when chemical residue is considered. The processors were not working optimally…most films which came out of the processors…had developer and/or fixer solution left on them…Regardless of how old the film is, filing and stacking the films would dry them out, but not remove the tacky solution problem. In this way, old films that were pulled out of their storage packets would quite often have solution on them. …
>
> If water was then applied to these films the solution could be re-dissolved and reactivated."

36. During my site visit I sought further clarification from the manager of the Radiology department, Mr Webb. He told me that although the term "wet films" is sometimes used to describe new films, they do not come out of the processor literally wet with water, and any films that came out with developer solution on them would keep developing and would be 'duds.' However, he agreed that sometimes fixer solution (from the final phase of the process) might not be completely washed off the film. Either this solution, or rinse water, could remain on a film but would quickly dry off. Traces of fixer solute might then remain. This solute might contain minute quantities of glutaraldehyde.

37. I note that most of this evidence was not inconsistent with what Mr Armstrong had to say. I accept that if there was anything on the surface of the films when Mrs Robertson touched them, it was most likely to be a residue of the solute from the fixer solution, left behind because the rinse phase was not as thorough as it should have been, and capable of being reactivated when water was applied.

38. Mr Armstrong told me that the presence of traces of residue on an X-ray was not something confined to the respondent's radiology facilities. Dr Hodge stated that he had received indications to the same effect from radiographers also, although he had no first hand knowledge of this.

39. Mrs Robertson told me:

> "During my time at WDHB I was never told that the freshly developed damp x-ray films were a potential hazard. Nor was I told that leaking x-ray processors, exposed glutaraldehyde or fibreglass dust were potential hazards."
>
> "…I was never advised or told that it would be a wise precaution for me to wear gloves or use barrier cream while handling damp x-ray films or other chemicals. It was never suggested to me that it would be a wise precaution that I wear a facemask…
>
> I have never been informed by WDHB of the specific chemicals present in my various workplace environments, in particular the Radiology Department. Although I filled out a questionnaire about my allergies prior to commencing my employment with WDHB I was not allergic to anything at that time…

40. The radiology department had in place certain policies for the purpose of protecting health and safety. These included:

- emergency response procedures in the case of hazardous substance spills;
- guidelines for cleaning x-ray processors;
- chemical safety policies;
- ventilation and air quality monitoring;
- systems for reporting incidents to the Health and Safety Service (which were used by the applicant following successive incidents as described above.)

41. Mrs Robertson however told me that WDHB's Health and Safety Policy Statement:

> "may have been kept in a book somewhere but I did not know where the book was and no-one ever told me that I should go and read the policy…"

42. On **28 August 2000** Injury Management New Zealand wrote to Mrs Robertson advising:

> "Re…Contact Dermatitis
>
> …this claim has now been accepted as a gradual process work injury under Section 39(d) of the Accident Insurance Act 1998. This means you have cover under the Accident Insurance Act 1998 for this injury."

43. Mrs Robertson continued to receive earnings related compensation until she eventually returned to the workforce in August 2002.

44. Meanwhile, in light of Mrs Robertson's additional symptoms, Dr Emrys had referred her to Dr Karalus, a respiratory physician. Dr Karalus replied on **4 September**, saying that that unless Mrs Robertson was developing shortness of breath (dypsnoea) with these exposures then a further referral to Dr Rademaker was more appropriate. Dr Emrys accordingly arranged this.

45. On **12 September 2000** Dr Emrys again clinically reviewed Mrs Robertson's case. His advice did not change although he noted that the question whether she would ever be able to return to her old job was for Dr Rademaker to advise on.

46. Redeployment attempts started with a work trial on **18 September 2000**. It lasted three days before being terminated when Mrs Robertson suffered a further reaction and was sent home. Dr Emrys saw her on **28 September 2000** at which time he recorded in his notes that she attributed her reaction to having come into contact with people who had been working in the Radiology Department.

47. In **October** Injury Management New Zealand arranged for Mrs Robertson to see Dr Karalus. His report noted that the identified allergens were not confined to photography but could also be contained in certain hair dyes, hair bleaches, decolourising and deodorising oils and in the making of soluble starch. Dr Karalus recommended a challenge test to determine whether or not the applicant was suffering from asthma.

48. On **19 October**, at Dr Emrys initiative, Mrs Robertson saw Dr Rademaker again. He told me that she was now reporting a reaction that differed from that which he had observed earlier; it now looked like contact urticaria. His report noted that:

> "She has had several episodes of urticaria occurring whilst at work. The first episode involved her hands and upper arms, and more recently affecting her hands and face. The rash appeared very quickly and settled over a

number of hours. This is clearly different from the allergic contact dermatitis reactions to metol and ammonium persulphate she had had before. It is much more suggestive of a contact urticaria."

49. Urticaria (often called hives) refers to a group of disorders in which wealing occurs in the skin as a result of the release of chemicals such as histamine which cause small blood vessel leakage and tissue swelling. Urticaria may or may not involve an allergic (immunologically mediated) response. In the words of Dr Hodge an immunologically mediated reaction:

"results from the development of a specific allergy to a chemical substance and is unique to the patient who suffers it; that is to say, it is not a reaction which can be expected to develop."

50. Contact Urticaria may therefore result from allergic reactions to chemicals (such as those in cosmetics and textiles, and latex) as well as non-allergic reaction to certain plants, animals, and medicines. A well-known example of an urticaria that is irritant rather than allergic in nature is the universal reaction to stinging nettles. Even when allergic in nature urticaria produces an immediate reaction, whereas the reaction produced by allergic contact dermatitis is delayed.

51. Dr Rademaker told the Authority that both conditions can be induced by the same environmental triggers, but stated:

"I have been unable to find any reports in the literature of contact urticaria occurring as a result of exposure to X-ray plates and I suspect this sort of condition is very rare."

52. His report also noted that the most likely allergens in a hospital environment would be gluteraldehyde and latex. Mrs Robertson had already been tested negative for the former and was now tested for latex allergy.

53. Between **6 and 8 November 2000** two further work trials were conducted in the recruitment and training centres but were discontinued when touching the WDHB logo on its letterhead caused Mrs Robertson to experience a skin reaction.

54. On **30 November 2000** Dr Rademaker reported that Mrs Robertson's latex allergy tests had proved negative. However he noted that she was now reporting a feeling of constriction in her throat after doing large amounts of photocopying, when filling her car with petrol or when walking past the cleaning fluids at the supermarket. Dr Rademaker concluded:

"I have no doubt that Robyn has allergic contact dermatitis but how this relates to her feeling of throat constriction I do not know."

55. In **December** of that year the Occupational Safety and Health Service commenced an investigation into Mrs Robertson's case.

56. On **22 December** the results of the challenge test indicated considerable doubt that Mrs Robertson had asthma.

57. On **24 January 2001** Mrs Robertson commenced a further work trial in the corporate centre but it was abandoned after photocopying and printed materials caused her to react with respiratory symptoms.

58. In approximately **February 2001** a change in personnel at the Public Service Association saw organiser Marian Rillstone take over the file.

59. On **27 February 2001** Mrs Robertson and her union delegate, Lyn Kiddie, met with Dr Emrys again. He recorded in his notes:

"Robyn reports having to make many changes to her normal life. She avoids the use of aerosols, when shopping she cannot pass photographers, film processors, vegetable stores, pharmacy etc.

I advised Robyn that her best prospects for maintaining in work probably remain at Waikato Hospital. Controlled environmental situations, such as computer rooms could be a suitable area for employment.

Advised an overview of the clinical situation could be provided by Professor Des Gorman, Head of Occupational Medicine, Auckland University, as he has an interest in respiratory and skin sensitisation."

60. As a result on **26 March** Professor Gorman undertook a clinical audit by way of file review on Mrs Robertson's case. His report opens with the following description of clinical audit by file review:

"As you are aware, a clinical audit by file review is common medical practice and is acceptable to ACC, to the Royal Australasian College of Physicians, to the Medical Protection Society and to the Health and Disability Commissioner providing certain conditions are met. These conditions are that the facts of the person's case must be clearly established and that any subsequent commentary must be limited to an interpretation of these facts. In the context of someone's health, the facts are the person's history, clinical and investigation findings. Many lay people mistake diagnosis as another fact. However, it is rarely the case. Instead, a diagnosis is an interpretation of facts and in classical medicine is presented as a list of alternative explanations, in order of decreasing likelihood. This is known as a differential diagnosis."

61. In response to the question "please explain how Robyn's apparent multiple sensitivities relate to the original diagnosis of contact dermatitis" Professor Gorman's report contained the following:

"From a diagnostic perspective, Robyn has only one clearly established health problem and several presumptive health problems. It is clear that she has both a contact and allergic dermatitis. She has a skin allergy to several components that used to be used in the development of X-rays. Quite appropriately, she has been advised to withdraw from work with such X-rays.

It is probable that Robyn satisfies the research classification criteria for a multiple chemical sensitivity syndrome. You need to be aware that the diagnostic criteria for this syndrome are so broad that that it is very inclusive. It is highly unlikely that there is any underlying single pathological entity that accounts for the multiple chemical sensitivity syndrome."

62. Professor Gorman went on to say that the contact and allergic dermatitis were probably a direct poisoning effect but other factors (such as those involving olfactory stimuli-induced fatigue and distress) were thought to be due to either 'neural conditioning' or 'kindling' and:

"A lot of people with such a syndrome also have some learned and/or behavioural component to their disability."

63. Dr Emrys explained to me that: "neural conditioning is a neurophysiological, somatoform response, that is to say, it is a physiological response to a psychological stimulus. In other words, it is a cognitive rather than a psychiatric problem. It is not uncommon for suffers of allergies to develop Multiple Chemical Sensitivities. Essentially, the body's systems malfunction after the development of a response to one or more allergens."

64. Professor Gorman also recommended that Mrs Robertson be referred to Dr Andrew Veale, a respiratory physician, for comprehensive respiratory function testing. Dr Veale concluded that Mrs Robertson had contact dermatitis and non-specific bronchial hyperresponsiveness, and recommended that Robyn be referred to a respiratory physiotherapist for training in diaphragmatic breathing.

65. Meanwhile, Injury Management New Zealand had referred Mrs Robertson to Career Services and she attended an appointment there on **16 March 2001**. With the assistance of this service she prepared a return to work vocational assessment and C.V.

66. OSH reported the outcome of is investigation in **April 2001.** It advised that no action would be taken against the respondent and that WDHB had taken "all practicable steps" to manage risk in the applicant's work environment.

67. In response to a request by Mrs Robertson, OSH re-opened its investigation into her case on **27 June 2001.**

68. On **5 July** and **9 August 2001** representatives of the respondent met with the applicant to discuss her redeployment options. The second of these meetings focussed on setting up a work trial as receptionist in the Hocken Building Corporate Centre. Before it commenced, Dr Emrys conducted an assessment of the work environment and cleared it for trial by Mrs Robertson. Unfortunately he overlooked the fact that painting work was in progress nearby. The trial commenced on **10 August** and ended on **22 August 2001.**

69. Also in July on Mrs Robertson's behalf, Ms Rillstone canvassed the possibility of obtaining a further medical opinion. She approached a Dr Glass in Christchurch and obtained a CV from him to provide to IMNZ. However, the latter were doubtful of the utility of a further medical opinion and hence, did not give approval to fund it. The idea was not pursued.

70. A further meeting was held on **28 August 2001** to discuss the most recent work trial and what to do next. Mrs Robertson reported:

> "she had been trialling the receptionist position at the front entrance to the Hocken Building. The first week had been cut short due to paint smells. She said that this put her at risk. She wanted more communication so that others could know how she was feeling.
>
> Marian said that she had reacted to smells down in the area. These were cigarette smoke on clothes, exhaust fumes of vehicles outside the window and rural smells. Ruth asked her if she was able to identify any other smells that caused her symptoms. Robyn said that she was unable to identify specific smells because she reacted afterwards…
>
> Robyn said that she believed that both sides had given the position a fair go and that she did not want to pursue it."

71. Also in **August 2001** came the further OSH report into Mrs Robertson's case**.** This time it had narrowed its focus to four areas:

> "(1) whether Waikato District Health Board took all practicable steps to manage Robyn's exposure at Radiology
> (2) Ventilation within the radiology viewing bay area
> (3) Staff training at Radiology
> (4) Radiology Hazard Register."

72. On the first issue, OSH concluded that WDHB failed on two occasions to take all practicable steps to manage the applicant's exposure to environmental factors affecting her health at Waikato Hospital. These were:

- Following receipt by Health and Safety Services (Waikato Hospital) of the Accident/Incident Report Form on her acute reaction on 18 November 1999 it was at least seven days before any action was taken.

- No action was taken following another acute event of 18 April 2000. The initial reason for this (that Mrs Robertson was soon to see Dr Rademaker) was sound. However, even after his report was received in May 2000 it took a further three months (until August 2000) before management of her exposure was revisited by means of a clinical review conducted by Dr Emrys.

73. However, OSH accepted that:

"management of the case may not have changed had there been a review of the Dermatologist's report immediately it came to hand."

74. On the other three issues, OSH advised that the following improvement should be made:

"Re-implementation of glutaraldehyde monitoring;
Provision of appropriate signage to warn staff about maintenance/malfunction of processors and/or chemical spillage;
Hazard register updated and kept in known location."

75. These improvements were required by October 2001. No other action was taken by OSH except to recommend that Kodak be advised of Mrs Robertson's case so that Metol and Ammonium Persulphate could be placed on record as being associated with Allergic Contact Dermatitis.

76. As a result of discussions at the August redeployment meeting, Mrs Robertson underwent a computer skills test followed, in October and November, by computer training programmes at the respondent's expense.

77. Up until this point Mrs Robertson's union, the Public Service Association, had represented her. Towards the end of 2001 she became frustrated by what she saw as the slow progress with her redeployment and decided to approach a lawyer instead. She instructed Mr Collette-Moxon who obtained her file from Ms Rillstead, the PSA organiser who had been handling the case, in early 2002.

78. Neither of the parties sought to have Ms Rillstead give evidence to the Authority, despite the fact that she (along with Ms Kiddie) had represented Mrs Robertson throughout 2001. In particular, she had accompanied Mrs Robertson to several meetings to discuss redeployment. Of my own motion, therefore, I requested her to attend a witness interview. Also in attendance at this interview were Counsel for both parties as well as representatives of the respondent. Mrs Robertson did not attend.

79. In response to my questions Ms Rillstone stated that she had initially been very hopeful that Mrs Robertson would be redeployed into a suitable position, and in a timely fashion. However, she said that after the trial at Corporate reception (in the Hocken building) failed, she said she realised how vulnerable Mrs Robertson's health was and that finding a suitable placement might prove difficult. She said that she realised they would have to "*think outside the square*" to find something that would work for Mrs Robertson.

80. When asked whether she herself could identify a role within the hospital where Mrs Robertson would not have been exposed to perfumes, cleaning fluids and other strong smells, Ms Rillstone said that as time went on, she had become less optimistic about this.

81. I also asked her about the timeframes involved in the redeployment attempts, and Ms Rillstone told me that she believed things had moved slowly, which was very unsatisfactory for Mrs Robertson, but that this was a result of the challenges involved in finding suitable work for her. Ms Rillstone told me she believed WDHB had met its obligations in terms of the collective agreement redeployment provisions, and had met her own expectations with regard to retraining (having funded the one-on-one computer training for her.)

82. Overall, in the circumstances, she believed the WDHB, as Mrs Robertson's employer, managed the redeployment process well during the period she was also involved in it.

83. In **February 2002** Injury Management New Zealand wrote to Mrs Robertson as follows:

> "as you are aware we have received your prescription and doctor's visits receipts from September to January…
>
> Your GP, Dr Prinsloo, stated the other prescriptions are for asthma or other medical conditions. Under the Accident Insurance Act 1998, entitlements are available for treatment required directly resulting from the condition for which cover has been granted. The claim for cover was accepted on the 28th August 2000 for contact dermatitis.
>
> Medical Information does not provide a clear link between contact dermatitis and asthma or reactive airways syndrome. Therefore I regret to advise you that reimbursement for the other medication and consultation costs cannot be considered…
>
> If you are not satisfied with this decision, or there is something you do not understand, you should contact me immediately to discuss your concerns. I will explain the decision and will explain your right to ask that the decision be reviewed."

84. This decision seems a little surprising in light of what I heard, during the investigation, about neural conditioning, which would indicate that Mrs Robertson's on-going respiratory problems, whatever their precise pathology, are indeed linked directly to her original personal injury by accident. However for reasons which she did not explain to me, Mrs Robertson did not request a review of this decision.

85. Mr Collette-Moxon arranged a meeting with representatives of the respondent in **February 2002**. At that meeting he suggested two roles which the applicant considered might be suitable for her. These were occupational and physiotherapy assistants' positions. Further discussion and consideration of these roles followed once the job descriptions had been obtained, and it was common ground that there were parts of these jobs that would not be suitable for the applicant. On her behalf Mr Collette-Moxon suggested that the job descriptions be modified to suit her but the respondent took the view that the modifications sought were not feasible.

86. At a further meeting on **March 1 2002** (at which IMNZ was also in attendance) the applicant confirmed that she would not be able to take either position as it stood. Mrs Robertson told me:

> "I voiced my concern that I was unable to perform part of the Physiotherapy Assistant's position, in and around the hydrotherapy pool area which had been confirmed as containing chlorine. Regardless of Ruth Ross having acknowledged that working in and around this area was substantially less than half the job description, WDHB refused to remove this requirement from the job description."

87. Soon after this the parties attended mediation in an attempt to resolve the employment relationship problem.

88. After mediation the parties conducted a "walk through" of the occupational therapy and physiotherapy departments. The applicant told me:

> "Prior to the two walk through exercises, my request that I wear a mask during my time in the departments was refused. The reason given was that it would not be fair to patients if I wore a mask. I found it difficult to see how this could be the case, as a small painters mask is very unobtrusive…
>
> The chemical hypersol is a widely used cleaning agent in all clinical areas within WDHB. Whenever I smell or come into contact with this chemical I experience an adverse reaction. I am unable to go anywhere near a location where it had been used much…I experience an itchy face and throat, tingling mouth, tightening throat and burning nose.

89. Mrs Robertson found that the chemical smells in the physiotherapy department, particularly in the hydrotherapy pool area, were simply too strong, and decided on that basis that she could not take up a position in either hydrotherapy or physiotherapy. At that point attempts to redeploy Mrs Robertson at WDHB ended.

90. On **12 June 2002** Mrs Robertson received a letter from the respondent terminating her employment. It noted that it had attempted to locate suitable and safe alternative duties for her including:

| | |
|---|---|
| "Training department | 6,7 and 8 November 2000 |
| Recruitment Centre | 9 November 2000 |
| Administration Assistant – Corporate | 24 January 2001 |
| Receptionist – Corporate | 10 August 2001 |
| Occupational Therapy Assistant | 15 March 2002 |
| Physiotherapy Assistant | 15 March 2002" |

91. By the conclusion of her employment, Mrs Robertson was experiencing reactions to garden spray, toner, fresh newsprint, photocopied and faxed paper, and laser printed material. These reactions included skin redness and itching/burning, tightness in the chest and difficulty breathing. She attempted to deal with the problem at home by removing all likely stimulants from the house. These included air purifiers, heavily scented dishwashing liquid, floor bleach, and perfumed soaps.

92. With the assistance of IMNZ Mrs Robertson's search for suitable employment continued. She was eventually successful in obtaining work in August 2002. However, she continues to suffer adverse reactions to a number of stimuli. By way of example she told me that on Monday 11 November 2002 she experienced a severe reaction in her workplace which she thinks was related to having been in proximity to a photocopying machine when toner was being changed.

93. Mrs Robertson's husband told me:

> "I am angry that WDHB were so utterly reckless as to allow somebody to handle strong chemicals for so many years without protection. It seems ridiculous to me that no one could have foreseen Robyn's problems. Regardless of whether she is an unusual case or not, WDHB must accept responsibility."

94. Mrs Robertson gave me extensive evidence, which was confirmed by her husband and Ms Kiddie, of the devastating effect of her injury and subsequent loss of employment. The nature and severity of her sensitivity to chemicals has been such that she has become drastically restricted in the activities in which she can engage. As a result she suffered from feelings of isolation, depression and frustration. I accept that the overall experience has had a severe effect on all aspects of her life.

95. I asked Mrs Robertson what she had wanted from the respondent. She told me she expected:

- to be made aware of the potential dangers of handling X-rays;
- to be moved from the X-ray department sooner;
- support and regular contact, especially when she was off work.

96. I asked Mrs Robertson to comment on the evidence that X-rays are normally handled by clinical and administrative staff without protective measures and without any ill effects. She accepted that prior to her first reaction the respondent was unaware of the dangers to her, but said that after this the respondent should have taken more care.

97. At the investigation meeting I asked Ruth Ross to explain how she saw the respondent's role in relation to Mrs Robertson's case. She told me that initially, she considered it was to manage the risk in the work area (associated either with the environment or with the processes) so that Mrs Robertson could remain in her job. Later, it shifted to assisting with finding her a suitable job elsewhere, so she could get back to work. Otherwise she saw the responsibility for managing Mrs Robertson's case as resting with Injury Management New Zealand. In particular, the job of maintaining regular contact with Mrs Robertson was, as she saw it, theirs, and any failings in that regard were the responsibility of that agency.

*Further medical opinion*

98. As we have seen, Mrs Robertson's symptoms gave rise to diagnoses of contact dermatitis, reactive airways disease, and multiple chemical sensitivities. During the Authority's investigation, she sought a further medical opinion from Dr Hodge, a dermatologist.

99. In **December 2002**, a witness statement from Dr Hodge was lodged in support of the first limb of Mrs Robertson's claim. Dr Hodge did not give the date upon which he had seen the applicant but it appears to have been not long before the statement was prepared and lodged.

100. In it he says she has occupationally induced contact urticaria to a substance or substances used in the processing of X-rays. He bases this diagnosis on reports by the applicant that the swelling and redness associated with her skin reactions typically subsided within minutes or hours, unlike the visible signs of dermatitis which although similar, take longer to subside. He notes that repeated frequent attacks of urticaria can produce a clinical picture of dermatitis.

101. Dr Hodge notes in his statement that while Dr Rademaker considered at least some of Mrs Robertson's symptoms to be urticarial in nature, he also believed her to be suffering from contact dermatitis. Dr Hodge does not share this view, and told me that he considers all her symptoms to be attributable to urticaria.

102. Dr Hodge concedes that he has not identified the exact nature of her allergen but records that he has observed an urticarial reaction to the application of aqueous formalin (10%) (solution of formaldehyde) to Mrs Robertson's forearm. He records:

> "That is not to say that formaldehyde is necessarily the cause of her contact urticaria under the conditions to which she might be exposed. It does however demonstrate that she develops contact urticaria in response to this widely used chemical."

and:

> "While the area of her oral, nasal, and respiratory symptoms are outside my area of expertise simple logic would indicate that if the substance to which she has contact urticaria is volatile then a similar effect on mucus membranes would be expected. Instances of respiratory symptoms of an acute nature in patients with contact urticaria are well documented.
>
> "Contact dermatitis may be allergic or irritant in nature. Doctor Rademaker has exhaustively tested for contact allergic dermatitis and has not demonstrated any relevant allergens.
>
> The clinical presentation of a contact dermatitis in this case seems likely therefore to be contact irritant in nature."

103. Dr Hodge does not believe that Mrs Robertson has had Multiple Chemical Sensitivity at all. He believes that all her reactions, both skin and respiratory, have a single cause: formaldehyde. This compound is of course ubiquitous in any modern environment, and (he suspects) very

likely to be present in solution on X-ray film. (It is, of course, a gas at room temperature.) Dr Hodge also noted:

"Clearly the future employment opportunities for Mrs Robertson are limited by her formaldehyde sensitivity. Hospital environments are notorious for exposure to formaldehyde."

104. I asked Dr Hodge how he could be sure that the formalin to which he exposed Mrs Robertson had not given rise to a contact irritant urticaria rather than a contact allergic urticaria. He told me that formaldehyde does not usually give rise to a contact irritant urticaria.

105. Dr Rademaker told me that his opinion differs from that of Dr Hodge in the following respects.

106. Dr Rademaker believes that at the concentration of formalin Dr Hodge used, a simple irritant reaction is quite likely. Lower concentrations of formalin should have been tested to establish the likelihood of an allergic reaction. He said he considered most formaldehyde reactions to be irritant in nature, and noted that people who are formaldehyde sensitive to a significant degree react primarily to fumes (because it is found in most furnishings and is so volatile) and cannot, for example, enter most buildings.

107. Dr Rademaker believed Mrs Robertson's symptoms to be a mixture of both contact allergic dermatitis and contact urticaria, and notes that patients with dermatitis are probably more likely to develop contact urticaria because of increased risk of sensitisation through damaged skin. He agrees that her initial presenting symptoms did not fit a neat clinical picture of either urticaria or dermatitis; he described them to me as 'more like a chemical burn.'

108. Dr Rademaker remains unsure what specifically Mrs Robertson was reacting to. He expressed concern with the reliability of the method of testing used by Dr Hodge and informed me that there is no standard, accepted screening technique for contact urticaria. Dr Hodge did not dispute the latter comment.

109. Dr Rademaker told me that, although he considered his assessment and Dr Hodge's to be largely in agreement:

"there is absolutely no possibility that WDHB misdiagnosed Robyn."

110. Even if it had, he said the treatment would in any event have been the same: avoidance of the responsible allergen:

"Having identified that Robyn had a positive reaction to metol and ammonium persulphate, the advice was to avoid contact with X-ray plates. This is the same advice I would have given to patients who had a contact urticaria reaction to x-ray plates."

**Consideration of "Report of a Ministerial Inquiry into the Management of Certain Hazardous Substances in Workplaces, July 2003."**

This Inquiry got underway during the course of my investigation. Its report was made public in July 2003, enabling me to take the opportunity to consider it in relation to my own investigation into Mrs Robertson's case.

Formaldehyde was one of the hazardous substances within the terms of reference of the Inquiry. It stated:

"Formaldehyde is a gas at room temperature. It is used most commonly as a formalin solution (formaldehyde dissolved in water with a small amount of methanol as a stabiliser) and as the solid polymer paraformaldehyde." (p.10.)

The Report recorded that it is widely found in workplaces and homes and can be the cause of indoor air-quality problems through "outgassing" from new products manufactured using formaldehyde. It is even more likely to be encountered in a hospital setting because of its use in laboratories (to prepare biopsy samples for examination) and as a disinfectant.

The Report contained the following recommendation in relation to Multiple Chemical Sensitivity:

"""That OSH should approach the subject of MCS (Multiple Chemical Sensitivity) as an occupational health issue by accepting the reality of the effects of MCS, by maintaining an actively open mind on the questions of the status and cause of MCS and by emphasising the taking of all practicable steps to reduce the risks from exposure to the Hazardous Substances, and other hazardous substances, which are associated with the onset of, or which can trigger the symptoms of, MCS."

(Section 10, Recommendation 8.)

## Conclusions

For convenience, I structure these conclusions in the same way that Mr Collette-Moxon has structured his argument.

### *1 The disadvantage claim*

*First issue: whether the Respondent has taken any unjustified action against the applicant (being a breach of express, statutory or implied terms or other unjustified action.)*

Clause 29 of the document which covered her employment from March 1999 set out certain responsibilities which, where relevant to this case, were consistent with the statutory framework. (Indeed it was succeeded with a provision, Clause 52 of the document which covered her employment from March 2001, that recorded that:

"The parties to this agreement agree to give effect to and comply with, the provisions of the Health and Safety in Employment Act 1992.")

Hence, the applicant relies on the same material facts to support her allegations of breach of express terms as she does to support the allegations of statutory breach. The particulars of the alleged breaches said to cause disadvantage to the applicant were set out in the particulars of 8 November. They are as follows:

"(1) The respondent did not take all reasonable precautions for the safety and health of Mrs Robertson. Additionally it did not take all practicable steps to ensure the health and safety of Mrs Robertson.

(a) Mrs Robertson was usually in daily contact with chemical agents used for the development of x-ray films, glutaraldehyde, processor fumes in addition to various other chemicals, including airborne substances, present in the medical environment (collectively 'chemicals') throughout her employment with the respondent.

(b) Mrs Robertson was not given any training about, or made aware of:
(i) The existence of the chemicals
(ii) Their effects
(iii) Their likely effects
(iv) The effects of similar chemicals

(c)Although Mrs Robertson was questioned about her allergies before she commenced employment with the respondent, the respondent did not take steps to update this information.

(d)Mrs Robertson was not provided with protective clothing, (including gloves, masks and barrier cream). Although this later occurred Mrs Robertson had already been affected by the chemicals to the detriment of her health.

(e)The respondent did not have a Health and Safety policy, or if it did, it was not displayed which caused Mrs Robertson to be unaware of it until in or about October 2001.

(2) The respondent failed to ensure that it had effective methods in place for systematically identifying both new and existing hazards to Mrs Robertson and for regularly assessing every hazard, which had been identified.

(a)The Respondent failed to undertake any such systematic assessments both of the chemicals and Mrs Robertson's particular duties.

(b)If this did occur, Mrs Robertson was neither informed of this nor was she involved in any such process.

(3) The respondent did not take any steps to eliminate or if impracticable to eliminate, to isolate, the significant hazard posed by the chemicals.

(a)The Respondent did not take any steps to consider a revision of its systems and policies in order for Mrs Robertson not to have to come into contact with the chemicals throughout the course of her employment.

(b)The respondent allowed Mrs Robertson to come into direct contact with the chemicals throughout the course of her employment without taking the simple protective steps of (including but not limited to) providing gloves or barrier cream or advising her to wear long sleeves.

(c)The respondent allowed Mrs Robertson to carry out her duties while exposed to the chemicals without taking the simple protective step of providing a mask (or any other suitable protective clothing).

(4) The respondent failed to minimise the significant hazard posed by the chemicals.

(a) As described in 3(a), (b) and (c) above the respondent did not meet its obligations in relation to minimising the significant hazard posed by the chemicals.
(b) The respondent failed to regularly monitor Mrs Robertson's health and in particular her exposure to the chemicals.
(c)If this did occur, the respondent did not take any steps to obtain Mrs Robertson's consent.

(5) The respondent did not provide Mrs Robertson with the results of any health-monitoring programme that may have been in place.

(6) The respondent did not ensure that Mrs Robertson was provided with information required under section 12 of the Health and Safety in Employment Act 1992.

(a)Mrs Robertson was not informed about the steps to be taken if a chemical emergency arose, in terms of an emergency where a person exhibited a reaction to one or more of the chemicals.

(b)The respondent did not inform Mrs Robertson of the hazard posed by the chemicals or the steps to be taken in order for her to minimise this hazard, as described above.

(c)The respondent did not inform Mrs Robertson of where all necessary safety clothing (including gloves barrier cream and masks) and other equipment was kept.

(7) The employer did not meet its obligations under s 13 of the Health and Safety in Employment Act 1992.

(a)The respondent did not take all practicable steps to ensure that Mrs Robertson had, or was supervised by a person who had, requisite knowledge and experience of the chemicals so as to ensure that she was not likely to suffer harm.

(b)As described in 1 (b) above the respondent did not meet its obligations in relation to training.

(8) The respondent did not ensure that Mrs Robertson had the opportunity to be fully involved in the development of health and safety procedures in her department.

(a)Mrs Robertson was never approached by the Health and Safety Department or any other such department of the respondent with a view to involving her in any such procedures.

(9) The respondent did not maintain a register of accidents and serious harm.

(a)If such a register existed it was not readily accessible to Mrs Robertson.

*Breach of Implied Term*

The applicant claims that the her terms of employment include an implied term such that:

"the applicant would not be directed to, or deployed in such a way as to, perform non-clerical (i.e. medical or specialised) duties in the course of her employment duties."

She alleges that the circumstances of her employment were such that she was effectively used in a specialist role in breach of this term.

**Findings**

**I am not satisfied that the evidence indicates a breach by the respondent of any statutory or contractual obligation (express or implied) or any unjustified action.**

*General Comments*

The following conclusions do not represent an exhaustive answer to every point the applicant has raised in relation to the allegations of breach and unjustified action, but instead cover the key elements of the issues raised in relation to those allegations.

In considering whether there were any breaches, I have had careful regard to the reports of the OSH investigations into Mrs Robertson's case. Mr Collette-Moxon has not suggested that there is any flaw in those investigations or that the recorded conclusions cannot be supported. I have no reason to suppose the investigations were not undertaken (as one would expect) by persons well qualified to do so. I note also that the investigations did indeed appear thorough and comprehensive.

Therefore, I take the reports on those investigations at face value. They indicate that there were no material breaches of duty by the respondent.

Overall, I remain unconvinced that the risk to Mrs Robertson was foreseeable. Her reaction to X-rays was more than unusual; it appears unprecedented. The respondent cannot be held responsible for failing to address a problem that no-one could foresee, before that problem manifested itself. I am satisfied that the steps the respondent took (once the problem did emerge) met its statutory and contractual obligations.

*Specific Comments*

(i)To deal with the last point first, I do not accept that Mrs Robertson was deployed in such a way as to perform clinical duties. She was not involved in the processing of X-rays and was not the first person to handle them as they came off the processor. That work was done by appropriately trained clinical staff. Her role was clearly administrative. Simply handling processed X-rays cannot in my view be described as a clinical task.

(ii) I am able to conclude that on occasions (possibly due to poor functioning of the processor) a residue remained on the surface of the X-ray films, and that this was most likely to be fixer residue which may have contained glutaraldehye. There has been no evidence to support the assertion that the applicant came into contact with any other hazardous substances or that she came into contact with the fixer residue on a daily basis. In short, the evidence is of very occasional contact with fixer residue, nothing else. This residue does not appear to have posed any sort of threat unless reactivated by contact with water and there is no evidence that even in such circumstances, any other staff had ever experienced an adverse reaction.

(iii) X-rays were normally kept dry. Indeed following Mrs Robertson's advice to the respondent that she had encountered X-rays which had got wet, all staff were reminded of the importance of storing them correctly and preventing them from coming into contact with any moisture.

(iv) It was not therefore a part of Mrs Robertson's normal duties to "work with chemicals." Contrary to the assertions made by Counsel, she was not in contact with chemicals on a daily basis. Any contact she had with active chemicals was minimal and unforeseeable.

(v) The hazard to Mrs Robertson appeared to be in or on the surface of processed X-rays. This may be associated with the fixer residue described above however Mrs Robertson's reactions do not appear to be limited to X-rays upon which a residue was present. It is not therefore possible for me to say on balance that the fixer residue was the likely cause of her problems.

(vi) I note that Dr Hodge believes that formaldehyde is the likely cause of all Mrs Robertson's problems. Dr Rademaker did not agree and pointed out that the test Dr Hodge performed is not conclusive. In addition, he observed that someone with an acute formaldehyde sensitivity would be unlikely to be able to tolerate a room such as that used for the Authority investigation meeting. Mrs Robertson did not find our meeting room especially difficult. The Report of a Ministerial Inquiry into the Management of Certain Hazardous Substances in Workplaces, July 2003 confirmed Dr Rademaker's evidence of the ubiquitous nature of formaldehyde in the air of any modern office or home. I cannot find it has been established that formaldehyde is the cause of Mrs Robertson's problems.

(vii) I note also that I was told that fixer solution does not contain formalin. If Mrs Robertson did have a particular problem with formaldehyde, it would not therefore appear to be related to any fixer residue present. I have also checked the Kodak Material Safety Data Sheets (MSDS) and formaldehyde is not listed as one of the chemicals present in its X-ray processing solution. Even if a formaldehyde sensitivity were established, therefore, the evidence falls a long way short of establishing a link between this and the workplace.

(viii) Mrs Robertson displayed an allergic reaction to Metol and Ammonium Persulphate, however it is not known whether these substances were ever present in fixer solution or otherwise found their way onto the surface of X-rays. All that can be said with certainty is that for Mrs Robertson X-rays posed a hazard, and that this is an extremely rare case. Clinical and administrative staff at Waikato Hospital and around the world handle X-rays safely without any special precautions being taken. It was not foreseeable, prior to Mrs Robertson's reaction, that X-rays would pose a hazard to her. It follows that there is no breach associated with failing to identify the hazard prior to her first reaction.

(ix) The applicant also argues that the respondent should have investigated the level of exposure to chemicals Mrs Robertson faced. This issue is clearly tied to the issue of hazard

identification. Prior to Mrs Robertson's first reaction, the respondent had no way of suspecting any need for such an investigation into what was present on the theoretically inert surface of a processed X-ray film. After her reactions, it took steps to investigate what might be present there (Dr Emrys's approaches to Kodak) as well as requiring her to wear gloves (an appropriate precaution whilst the exact cause of her problem remained unidentified.)

(x) The applicant alleges that the respondent failed to provide Kodak and other Material Safety Data Sheets to her. It is correct that although these were available within the department, they were not brought to her attention, in the same way that they were not brought to the attention of any staff who did not work directly with the processor itself. I do not find that the respondent was required to bring these MSDS sheets to the attention of Mrs Robertson, and in any event, have not been convinced that it would have assisted her in any way if this had been done.

(xi) The evidence does not support a finding that the respondent should have provided additional training to the applicant, indeed there is no evidence to indicate what, if any further training might have been helpful or appropriate in the circumstances.

(xii) I note also the submission that the respondent should have asked Mrs Robertson to update the information she had given it about her allergies. The applicant has not explained why the respondent should have done this, or what it would have achieved, since until her reaction, she had no new information to give. I cannot conclude that this amounted to a breach.

(xiii)I am satisfied that in 1999 and 2000 the respondent's Health and Safety Policies were not prominently displayed in the Radiology Department. However, I am not satisfied that there is any causal link between this failure and the disadvantage that the applicant suffered. I have checked the policies and find no evidence that the respondent failed to comply with its own policies.

(xiv) I accept that from the earliest indication that the applicant's health and safety was at risk through contact with X-rays, the respondent should have provided gloves to her. In relation to this point I note the OSH finding that there was a slight and preventable delay between the first sign of an adverse reaction (18 November1999) and the provision of gloves to Mrs Robertson (25 November.) I note however that there is also an issue around the clarity with which Mrs Robertson described her injury on 18 November, and I record that in the circumstances I do not consider this delay to amount to a breach.

(xv) In a similar fashion, the second delay to which the OSH report refers was unfortunate but again, as it does not appear to have had any material effect on the management of the applicant's problems, it cannot be considered sufficiently serious as to amount to a breach of duty.

(xvi) The provision of gloves amounted to an appropriate step to isolate the hazard to Mrs Robertson.

(xvii) Finally for completeness I note the other three issues considered by OSH when it re-opened its investigation of the case. Fumes were not an issue for Mrs Robertson while she still worked in the Radiology department, and while the three final recommendations were clearly useful for the department, any minor shortcomings in relation to glutaraldehyde monitoring, signage or the hazard register appear unlikely to have impacted in any significant way on Mrs Robertson personally.

*Second issue: whether any claim by the applicant is statute barred under the Injury Prevention, Rehabilitation and Compensation Act 2001 (IPRCA).*

In submissions, Counsel for Mrs Robertson referred to Reeves v Pyne Gould Guinness Ltd unrep, CEC 22/96, Palmer J and conceded that a claim for compensation arising directly out of her contact urticaria (as he says her skin complaint should be described) is statute barred on the basis that it amounts to personal injury under the IPRCA for which she received cover. He confirmed that she did not, therefore, seek compensation for distress arising directly out of the contact urticaria/dermatitis.

However, he says that for two principal reasons, this is not the end of her disadvantage claim.

His first argument is that Mrs Robertson has suffered disadvantage (her respiratory difficulties) for which she has not been compensated. He says that the evidence has established that this disadvantage was linked to the original event of contact urticaria, which was itself the result of alleged breaches by the respondent.

"The applicant's respiratory difficulties (as distinct from the irritant or allergic symptoms of dermatitis/urticaria) was [sic] not a personal injury for which she received cover. Cover was in fact refused. It is established on the evidence that the cause of her respiratory difficulties was the respondent's unjustified actions (i.e. that the applicant's respiratory difficulties flow from her urticaria which was itself caused by the respondent's breaches and/or unjustified actions.) Therefore compensation for disadvantage and distress is not statute barred and does not fall within the Reeves exclusion."

In submissions the respondent agreed that:

"whatever the precise diagnosis, at the hearing, the medical evidence supported a causal link between the applicant's original condition and the further conditions."

The respondent goes on to submit that it such a link exists, the further consequences are a consequence of and flowed from the physical symptoms caused by her exposure. Therefore the applicant is entitled to cover (Accident Compensation Corporation v Doyle Judge Ongley, DC Palmerston North AI 56/99.)

The respondent also submitted that *entitlement to cover* is the relevant issue in relation to the question whether the claim is statute barred, not the fact of whether cover was obtained. On this point the respondent referred me to Peter Urbani v Gillion and Sons Ltd (HC Dunedin CP 26/01, 14 May 2002, Master Venning.

Thus, the respondent submits that since the applicant was entitled to cover for all her symptoms, she is barred from bringing proceedings in respect of these injuries

**Findings**

(i)Section 318 of the Injury Prevention Rehabilitation and Compensation Act 2001, prevents proceedings seeking compensation for personal injury caused by work-related gradual process:

"318 Proceedings for Personal Injury caused by work-related gradual process, disease, or infection that is-

(1) This section applies to proceedings for damages arising directly or indirectly out of personal injury caused by a work-related gradual process, disease or infection that is-

(a) Personal injury covered by this Act; or
(b) personal injury covered by the former Acts

(2) No person may bring proceedings to which this section applies independently of this Act in any Court in New Zealand, whether the proceedings are under any rule of law or any enactment….

(3)

(4) However, no court, tribunal or other body may award compensation in any proceedings referred to in subsection (4) for personal injury of the kinds described in subsection (1)."

(ii)There is clear authority that an applicant cannot obtain damages for stress and humiliation flowing from personal injury covered by ACC legislation. (Reeves and Pyne Gould Guinness Limited, unreported, CEC 22/96.)

(iii) It is not in dispute that the evidence supports a causal link between the applicant's on-going symptoms (of Reactive Airways Disease and Multiple Chemical Sensitivity) and her skin condition (her original gradual process injury.) I share this view.

(iv) In Accident Compensation Corporation v Doyle Judge Ongley, DC Palmerston North AI 56/99 the District Court concluded that a worker's continuing symptoms (which appeared to have no organic cause and had been described as 'psychogenic') were the consequence of a workplace gradual process injury, and observed:

"The long term consequences, which do not fit into any known pattern of illness, would probably not have occurred but for the physical effect of the exposure that Ms Doyle experienced in the first place.

The parallels between that case and this are strong. There no evidence of any cause of Mrs Robertson's symptoms other than the personal injury she suffered in her employment. I am satisfied that but for her exposure to X-rays, she would be unlikely to be suffering her on-going and wide-ranging symptoms. Her respiratory and other difficulties are a consequence of and flow from the physical symptoms caused by her exposure. I conclude that this link entitles her to cover for all those symptoms.

(v) I also agree with the respondent's submission that *entitlement to cover* is the determinative issue in considering whether a claim is statute barred. The decision to decline cover to Mrs Robertson in respect of her additional symptoms was made at an administrative level, and it was Mrs Robertson's choice not to challenge that decision. Whether or not she 'has cover' is a question of law and is not finally determined at an administrative level, or by the exercise of a choice on her part.

(vi) The applicant is entitled, in my concluded view, to cover for all her symptoms. That entitlement makes any further claim for relief statute barred.

(vii) I note for completeness that it were to be established that, on the grounds cited by IMNZ, she was not entitled to cover, she would of course fail to establish a case here as well. In other words, it is my view that she cannot have it both ways. Either there is a link, she is entitled to cover, and her claim is statute barred, or there is no link she is not entitled to cover and she also fails to establish a connection with any breach by the respondent.

The second argument advanced by Mr Collette-Moxon in support of the applicant's disadvantage claim is that regardless of the fact of her injuries, the predominant causes of her distress were the fact of her removal and the respondent's conduct after the injury. This he says distinguishes her case from Reeves where the employer had simply been negligent prior to injury.

Under the head of disadvantage Mr Collette-Moxon refers me to issues surrounding the failed attempts to redeploy Mrs Robertson. I will deal with those issues in discussing the alleged dismissal grievance (below).

The other element of post-injury conduct on which he relies is in relation to the alleged misdiagnosis of the applicant. It is conceded for the applicant that "the preponderance of medical opinion establishes that her condition was rare." Nonetheless, on the basis of Dr Hodge's assessment of her condition it is submitted that she was wrongly diagnosed as having contact dermatitis when in fact she has contact urticaria. Mr Collette-Moxon points to Dr Hodge's advice that urticaria, which is far rarer than dermatitis, often has associated respiratory symptoms, and that patch tests for contact dermatitis are not able to demonstrate urticarial reactions. Mr Collette-Moxon argued that if the correct diagnosis had been made at the outset, correct testing of allergies should have occurred. This:

"Would have put the employer in better position to evaluate options for redeployment. Efforts to redeploy would have been more effective had the parties based them on a true clinical picture of her sensitivities"

Mr Collette-Moxon argues that responsibility attaches to WDHB as her employer for this misdiagnosis because Dr Rademaker saw Mrs Robertson in clinic at Waikato Hospital and so acted as the agent of the respondent.

Mr Collette-Moxon argues that the consequences of the misdiagnosis were severe in terms of the applicant "simply wanting to know what was wrong with her" but also, the redeployment process was affected, because if the diagnosis had been correct, "she may have been able to have been redeployed even within the department where she had spent 10 productive years." He did not, however, provide concrete examples to support the latter submission.

**Findings**

I reject the applicant's argument regarding alleged misdiagnosis in its entirety.

(i) There is no evidence to establish that there was a "misdiagnosis." There is nothing more than a recent second opinion which differs in some (but not all) respects from the original opinion given by Dr Rademaker and endorsed by Professor Gorman. Mr Collette-Moxon invites me to prefer that of Dr Hodge but has not explained why it is to be preferred. I note that Dr Rademaker's credentials seem very strong and that he had the benefit of seeing the patient when she first presented with symptoms, as well as on a number of subsequent occasions. I am aware of no reason to give his opinion anything less than equal weight to that of Dr Hodge. I note for completeness that the applicant was critical of the methodology of Professor Gorman's clinical audit by file review. I have recorded above the Professor's comments on his methodology and can find no basis for questioning its acceptability.

(ii) There was no evidence that Dr Hodge's diagnosis would have made any difference to the management of Mrs Robertson's problems or to the efforts to redeploy her. The medical opinions in my view are broadly consistent. Even if Dr Hodge's diagnosis is to be preferred, I am not satisfied that there is any disadvantage arising out of the differences between it and that of Dr Rademaker.

(iii) If there was a misdiagnosis, it was not made by the respondent in its capacity as Mrs Robertson's employer. It was made by a clinician (Dr Rademaker) who first saw Mrs Robertson as a patient on a referral from her G.P. At that time, there were no dermatologists in solely private practice in the Waikato. Until I hear evidence to the contrary (which I have not) I presume that the normal ethics of the medical profession governed her assessment and

treatment. There is no evidence to suggest that the normal doctor-patient relationship between Dr Rademaker and Mrs Robertson was in any way affected or disturbed by the fact that he saw her as a patient at Waikato Hospital. (I also note that she did not seek a second opinion from Dr Hodge until December 2002.) In short, the doctor-patient relationship that subsumed between Mrs Robertson and Dr Rademaker was an entirely separate matter from her employment.

### *2 The alleged unjustified dismissal*

Mrs Robertson says that from February 2001 until June 2002 she attempted to renegotiate her redeployment with the respondent. She says that the respondent's failure to redeploy her and the subsequent termination of her employment amounted to an unjustified dismissal. She also submits that the respondent:

"(a) Failed to conduct its negotiations in a procedurally fair manner" and

(b) breached its obligations in relation to misleading or deceptive conduct:"

Specifically:

- meetings held at her solicitor's offices prior to her dismissal were essentially a sham;
- she was not listened to;
- there were excessive delays between steps;
- despite a number of suitable jobs being available with the respondent, meaningful redeployment options were not proposed;
- the respondent did not confer with the applicant before it issued its letter of 12 June 2002 terminating her employment;
- the respondent was merely 'going through the motions;'
- there were few redeployment offers for an organisation of this size, and none were suitable;
- the respondent failed to identify the risk associated with the paint fumes in the Hocken Building, showing a lack of good faith;
- the refusal to modify the physiotherapy assistant position also shows a lack of flexibility and good faith.

In regard to the question of substantive justification, it is submitted for the applicant that:

> "a fair and reasonable employer would not have considered dismissal in the circumstances"

The applicant argues that these circumstances include her seniority and abilities as well as her long and exemplary service, and her repeated desire to continue working for the respondent. Again, she notes that there were only two full job trials and that these were, in her view, unreasonable. In contrast she notes that in the period from June to August 2002, IMNZ arranged for her two work trials and at least four interviews with prospective employers. It is submitted on her behalf:

> "Although the applicant's sensitivities were debilitating, they were not so severe as to prevent her from performing useful and everyday tasks. It is simply that care needs to be taken with regard to the applicant's exposure to formaldehyde."

**Findings**

(i) There is no evidence at all to support the contention that the respondent engaged in misleading or deceptive conduct. Over a two year period the respondent met with the

applicant on numerous occasions and conducted a series of work trials. The applicant had the benefit of representation throughout.

(ii) I am satisfied that the attempts to redeploy were genuine and satisfactory.

(iii) The evidence does not support the contention that the meetings at the applicant's lawyer's offices were a sham. The respondent followed up, in a proper fashion, the applicant's request to explore jobs in the Physiotherapy and Occupational Health Departments.

(iv) Although it is correct that in such a large organisation, a significant number of vacancies came up all the time, it is also the case that the severity of Mrs Robertson's difficulties rendered the vast majority unsuitable. In particular, her condition precluded her from any roles in or near a clinical setting.

(v) Part of the investigation meeting was taken up with a careful perusal of vacancies contained in the respondent's Insider magazine. Between us, Counsel and I checked dozens of vacancies. Of those identified as potentially suitable for Mrs Robertson, most had been explored as part of the redeployment attempts. There appeared to be only two or three at most that may have been overlooked, and these were not ideal.

(vi) Of all the vacancies that came up during the two year period during which attempts were made to redeploy Mrs Robertson, I am satisfied that the position as receptionist of the Corporate Centre in the Hocken Building was the most suitable.

(vii) I inspected this location as part of my site visit to Waikato Hospital. I was accompanied by Counsel as well as by representatives of the respondent and by Mrs Robertson. The building houses administrative staff only and contains no clinical facilities. The reception area in question is quiet and is not accessed by members of the general public. The workstation was comfortable and spacious, indeed a marked improvement upon the area in which Mrs Robertson had worked in radiology. It appeared ideal. However, during the brief period in which we were present in the area, Mrs Robertson experienced an adverse reaction which I witnessed for myself. It appeared to have been triggered by fumes from cleaning fluids drifting from the nearby toilet facilities which were being serviced at the time.

(viii) I observed for myself Mrs Robertson's breathlessness and distress. This served to illustrate for me the futility of attempts to redeploy Mrs Robertson within a hospital environment. Quite simply, I am satisfied that if Mrs Robertson could not work in the Hocken building, she could not work anywhere in the hospital setting.

(ix) The applicant has asserted that the respondent did not consult with her before it decided to dismiss. I find, quite to the contrary, that it continued its efforts for many more months after the Hocken Building trial failed, paid for computer training for her and met on several more occasions with her and her lawyer before exploring further job options at her request. Even with modifications, these jobs were clearly unsuitable. The respondent consulted with Mrs Robertson as fully as it could in the circumstances and had exhausted all avenues open to it.

**(x) The respondent proceeded to dismiss only after extensive efforts had been made to assist, retrain and redeploy the applicant. The dismissal was conducted in a procedurally fair manner and was justified on the grounds of incapacity.**

**Summary of Conclusions**

As should be clear from the foregoing, I can do nothing more to assist Mrs Robertson with her employment relationship problem. My principal findings are that her personal injury was not foreseeable, and that the respondent took all reasonable precautions in respect of her safety. In addition, I conclude that a claim in this jurisdiction is statute barred. Finally I accept that the termination of her employment was justified on the grounds of incapacity.

She is not entitled to the remedies she seeks.

Before concluding, however, I wish to stress to Mrs Robertson that this finding in no way intended to minimise the seriousness of her health problems and the devastating effects they have had on her life. I am well aware that she has suffered enormously as the victim of a rare and largely unexplained condition. I can only express a hope, for her and for other sufferers of similar conditions, that new light will be shed on the causes of such problems so that both prevention measures and treatment can be improved.

**Costs**

The parties are invited to discuss this issue between themselves. If however this proves impossible, they have a period of 28 days in which to lodge any application for costs. Upon receipt of such application the Authority will advise the other party of the timetable for response.

Y S Oldfield
Member of Employment Relations Authority