WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

Issued in accordance with section 294 of the *Workplace Injury Management and Workers Compensation Act 1998*

Matter Number: **4619/20**
Applicant: **Bernadette Massih**
Respondent: **Serco Australia Pty Ltd**
Date of Determination: **6 January 2021**
Citation No: **[2021] NSWWCC 3**

The Commission determines:

1. The applicant suffered psychological injury namely a major depressive disorder arising out of and in the course of employment with the respondent.

2. The injury is deemed to have occurred on 29 August 2019 for the purposes of the Workers Compensation Act 1987 (the 1987 Act).

3. Remit the matter to the Registrar for referral to an Approved Medical Specialist to certify the degree, if any, of whole person impairment as a result of the psychological injury referred to above.

4. Request the Approved Medical Specialist to state his reasons for acceptance or rejection of the psychometric testing carried out by Dr Phillips.

5. Approved Medical Specialist to have access to the documents referred to in [16] together with a copy of my reasons for this decision.

6. On receipt of the Medical Assessment Certificate list the matter for telephone conference to deal with the issues of weekly payments and medical expenses medical expenses.

A brief statement is attached setting out the Commission's reasons for the determination.

Paul Sweeney
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF PAUL SWEENEY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

L Golic

Lucy Golic
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

INTRODUCTION

1. Bernadette Massih (the applicant) was employed as a Detainee Services Officer at the Villawood Detention Centre by Serco Australia Pty Ltd (the respondent) between February 2019 and 28 August 2019.

2. It is evident that during the period of her employment the Villawood Detention Centre was a difficult and, possibly, dysfunctional work environment. The applicant alleges that she was subjected to constant bullying and harassment by a fellow employee. Her evidence on this aspect is not contested by the respondent.

3. The applicant ceased work on 28 August 2019. She made a claim for compensation for a psychological injury resulting from her employment. The respondent accepted the claim and paid the applicant compensation.

4. On 17 August 2020, the respondent's insurer, EML, issued a Notice under section 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) by which it advised that the applicant's weekly payments would cease on 12 October 2020. The notice stated that the applicant was no longer entitled to weekly compensation or medical and hospital expenses pursuant to section 60 of the *Workers Compensation Act 1987* (the 1987 Act) as she had not suffered a psychological injury in accordance with sections 4 and 11A (7) of the 1987 Act.

5. The respondent's denial of liability was largely based upon the opinion of Dr Paul Phillips, a psychologist, who saw the applicant on 5 June 2020 and carried out a series of psychometric tests. On reviewing the results of those tests, Dr Phillips concluded that the applicant was malingering.

PROCEDURE BEFORE THE COMMISSION

6. The matter initially came on for telephone conference on 16 September 2020 when the parties were represented by their respective solicitors. At that time, I was advised of the employer's decision to decline liability to pay compensation to the applicant and to put in issue the occurrence of a psychological injury.

7. As the Application to Resolve a Dispute (the Application) was limited to a claim for permanent impairment compensation, it was necessary to grant leave to the applicant to amend it by adding a claim for weekly payments of compensation and medical expenses. I also gave leave to the respondent to lodge a Reply enclosing the documents on which EML based its decision to deny liability to pay compensation to the applicant. I gave leave to the applicant to respond to this material and set the matter down for conciliation and arbitration on 2 November 2020.

8. When the matter came on for a conciliation conference and arbitration hearing over the telephone on 2 November 2020, Mr Tanner, of counsel, represented the applicant and Mr Beran, of counsel, represented the respondent. I was informed by the parties that they were unable to resolve the threshold dispute in respect of injury. I am satisfied that the parties, who were represented by experienced counsel, had ample opportunity to consider settlement but were unable to reach a mutually satisfactory resolution.

9. The time allocated for the arbitration hearing was almost entirely consumed by two applications by the respondent. First, Mr Beran sought to tender an email which apparently stated that the sender had observed the applicant dressed in a uniform and performing actions consistent with employment in a shopping centre in January 2020.

10. Surprisingly, the tender of the email was objected to by the applicant. Arguably, it would have been preferable for the applicant to deal with the issue at the arbitration hearing, although I appreciate that there may have been practical difficulties in adopting this course.

11. After hearing argument, I rejected the tender of the document. The respondent had not served the document on the applicant. It had not referred to the availability of the evidence at the telephone conference on 16 September 2020. It gave no explanation as to why it had not responded to the information in the email or carried out further enquiries concerning the allegations in the nine months prior to the arbitration hearing.

12. Mr Beran then sought leave to cross-examine the applicant. With some reluctance I also ruled against this application. The matter was conducted as a telephone arbitration. It is not feasible to conduct cross-examination over the telephone. If the respondent had raised the need to cross-examine the worker at the initial telephone conference, I would have arranged for an audio-visual or, if permitted by the President, a face-to-face arbitration hearing. Giving leave to Mr Beran to cross examine would have necessitated an adjournment of the matter to a further hearing date in the New Year.

13. I gave reasons for my rulings at the arbitration hearing. I appreciate that the refusal of leave to cross-examine may restrict the respondent's ability to present its case at its highest. However, in the circumstances both the balance of convenience and the interests of justice dictated that the appropriate ruling was to reject the application and determine the question of injury.

14. Determination of permanent impairment by an Approved Medical Specialist would not put an end to the respondent's right to subsequently test the applicant's evidence in respect of her alleged post-injury employment at a further arbitration hearing.

15. Prior to the conclusion of the arbitration hearing, I issued a direction requiring the applicant to lodge and serve written submissions by 23 November 2020 in respect of the issue of psychological injury and the respondent to reply by 7 December 2020.

EVIDENCE

16. The following documents are in evidence before the Commission:

    (a) The Application and the documents attached;

    (b) The Reply and the documents attached, and

    (c) Applications to Admit Late Documents dated 23 September 2020 (x 2), 29 September 2020, 12 October 2020, and 27 October 2020.

17. At least in respect of the issue of injury, counsels' submissions raise no objection to the evidence enumerated above. Other than the applications made by Mr Beran, which I have set out above, there was no further application to adduce evidence at the arbitration hearing.

18. It is evident from what I have said above that the only issue for determination is that of the occurrence of psychological injury. It is appropriate in the unusual circumstances of this case to determine that issue at the outset. If the applicant establishes injury, the issue of permanent impairment as a result of psychological injury can be assessed by an Approved Medical Specialist.

19. On receipt of the Medical Assessment Certificate (MAC) the Commission can determine the remaining issues including weekly payments and entitlement to medical expenses. While the process is unwieldy, it diminishes the possibility of inconsistent outcomes: see *Jaffarie v Quality Castings Pty Ltd* [2017] NSWWCCPD 2 (28 February 2017). It also has the advantage of permitting the respondent to ventilate the issues in respect of post-injury employment at a further hearing, if it so chooses, and at the same time enables some progress to be made in the determination of the primary issue.

Submissions

20. The submissions of the parties are in writing. It is appropriate to briefly recapitulate the general thrust of counsels' arguments below.

21. Mr Beran submitted that the respondent sought:

> "An order that either the Applicant did not sustain an injury in the form of a psychological injury, or alternatively, that any psychological injury sustained by the Applicant has resolved and the Applicant presents with malingering that is not a compensable injury."

22. Mr Beran submitted that where there is a claim for permanent impairment compensation pursuant to section 66 of the 1987 Act, it was open to the Commission to determine both injury and the nature of the injury. He referred to the reasoning of Deputy President Snell in *Inghams Enterprises Pty Limited v Belokoski* [2017] NSWWCCPD 15 and the reasoning of Leeming JA in *Jaffarie v Quality Castings Pty Ltd* [2018] NSWCA 88.

23. Mr Beran also argued that the repeal of section 65(3) of the 1987 Act permitted the Commission to determine that an injury had resolved prior to its determination. In those circumstances, there would be no basis for the referral to an Approved Medical Specialist of a claim for permanent impairment.

24. Mr Beran argued that the case should be determined by reference to the evidence of the specialist psychiatrists and psychologists. In resolving the conflict between these medical practitioners, the report of Dr Phillips, neuropsychologist dated 5 June 2020, was critical. He continued:

> "At page 2 of his report, Dr Phillips clearly identifies the first stage of any assessment process is that of ruling out malingering. Dr Phillips furthermore identifies the acceptance and validity of his assessment process and the use of psychometric testing, in this case, MMPI-2, MMPI-2-RF and PAI. Indeed, Dr Phillips utilises many pages of his report to identify the acceptance of such testing not only in Australia but throughout the world. It is noted that Dr Phillips conducted a mental status examination at page 17 of his report."

25. Mr Beran submitted that Dr Phillips found the applicant had exceeded the cut-off "for potential malingering in 21 of the 21 scales assessed". He referred specifically to the paranoia scale where the applicant had "scored higher than 99.999999997% of people (3 in a million)."

26. The fact that Dr Phillip had concluded that the applicant had received similar results in all 21 tests that he performed to verify her truthfulness:

> "would seriously bring into disrepute her presentation on clinical examination to all medical practitioners and the sole reliance upon the mental state examinations as being questionable at the least and erroneous at worst."

27. Mr Beran submitted that the opinion of Dr George was also important as he accepted that the applicant had major depression with anxiety on his initial examination. It was only after reviewing the neuropsychological testing that he "cautioned against accepting the Applicant's previous diagnosis."

28. By contrast, little weight could be given to the supplementary opinions of Dr Khan, the applicant's treating psychiatrist, and Dr Rastogi, a psychiatrist who provided a report to the applicant's solicitors. They had not engaged with the results of the testing carried out by Dr Phillips. These doctors did not explore the possibility that the neuropsychological testing may have some relevance for their diagnosis. Rather, they attacked its validity and the reasoning of Dr Phillips. He continues:

> "Dr Rastogi at no stage engages with any diagnostic requirement of the DSM, and it is on this basis that the respondent again submits that Dr Rastogi has removed herself from the realms of being an independent medical examination to being an advocate for the applicant and her opinion cannot be given any weight."

29. Finally, Mr Beran submitted that the applicant's credibility had been undermined by the psychometric testing which demonstrated that the clinical examinations undertaken by the treating and qualified psychiatrists were "inherently unreliable and should not be given any weight".

30. If the Commission found, based on the opinions of Dr Phillips and Dr George, that the applicant was malingering there would be no grounds for a referral to an Approved Medical Specialist. In the alternative, if the applicant suffered a psychological injury but was found to be malingering by the time of the tests carried out by Dr Phillips, the Commission would find that:

> "Any psychiatric injury has resolved and that the Arbitrator is entitled to enter an award of 0% WPI pursuant to s66 due to the recent appeal of s65(3)."

31. Mr Tanner submitted that all the medical practitioners and allied health professionals who had examined the applicant, save for Dr Phillips, had opined that she met the DSM-5 criteria for psychological injury. He referred to the opinions of Dr Calvache-Rubio, and Dr Lim, the general practitioners who had treated the applicant, Dr Nielsen, one of her treating psychologists, and the opinions of Dr Khan and Dr Rastogi.

32. Dr George had examined the applicant on two occasions and on each occasion had carried out a mental state examination. On each occasion, he had diagnosed "major depression with anxious mood". He noted there was some consistency between the applicant's presentation to him and to Dr Rastogi on 15 May 2020. After considering the psychometric testing performed by Dr Phillips, Dr George expressed the view that accurate diagnosis of the applicant caused "a quandary": as on clinical examination she continued to present with ongoing symptoms of psychological illness.

33. Mr Tanner argued that Dr George had not at any stage clearly repudiated his original diagnosis of major depression. Rather, he has suggested that it may be appropriate to refer the applicant for further forensic testing which, if consistent with Dr Phillips results, would make it difficult for him to maintain his diagnosis. Mr Tanner submitted that none of the tests conducted by Dr George had been undertaken.

34. The final report of Dr George of 3 August 2020 contains an opinion that was based on a false assumption, namely that the applicant's treating psychologist and psychiatrist had negatived the likelihood that she presented with suicidal ideation.

35. Further, Dr George did not positively opine that the tests of Dr Phillips should be accepted, and that the applicant was malingering. Rather, he expressed “a measure of uncertainty” in his opinion in that he was not able to hold to his clinical opinion “with any confidence”. Mr Tanner continued:

> “It is relevant that Dr George had maintained his diagnosis of major depression after being provided by Dr Phillips report in June 2020. He plainly required more testing before being persuaded that his clinical findings were not reliable. No such further testing was conducted and it would follow that Dr George had no basis to change his opinion.”

36. Mr Tanner also argued that the results of the psychometric testing in June 2020 did not provide any proper basis for a finding that the applicant did not suffer the psychological injury in August 2019. Theoretically, they might give rise to a finding that the effects of injury had ceased but they did not negate the diagnosis of doctors 12 months earlier. All the medical practitioners, who had observed the applicant during this period, had consistently reported a psychological illness which they related to employment.

37. In order to understand the above submissions and the way in which the Commission has resolved the issues in dispute, it is necessary to first set out in summary form the evidence of the applicant and the opinions of the psychiatrists who have examined the applicant and of Dr Phillips, the neuropsychologist. I do so compendiously without attempting to survey the entirety of the evidence of each witness.

THE APPLICANT

38. By a signed statement dated 15 August 2020 the applicant described the nature of her work as a detainee services officer at Villawood. She states that she was initially involved in a 6-week training course to obtain a Certificate II in Security.

39. The applicant says that she was picked on and bullied by one of her colleagues and there was “constant bullying in the classroom and this was addressed to HR.” She continues:

> “My other colleagues in the course formed a WhatsApp group chat despite being warned by HR that this was not allowed. Emily was targeting me, belittling me and making derogatory statements and spreading rumours that impacted my reputation. One of my colleagues sent a screenshot about a WhatsApp conversation to me which eluded I was a ‘snitch’ and making demeaning comments.”

40. The applicant says that after she completed the course Emily “continued talking negatively and bad-mouthing me to other colleagues”. Emily would threaten her and state that she desired for her termination. The applicant says that she felt victimised and targeted and under constant scrutiny. She also states that she was given unrealistic tasks and “thrown into the deep end”.

41. When the applicant requested that Emily stop harassing her and they “make peace and move on”, Emily instigated a formal grievance against her, so that she would be terminated from her employment.

42. The applicant says that she reported all of these matters to HR and they did not reply. She felt “isolated and dismissed”. She states that she started developing fear and anxiety at work. She would try and avoid interaction with Emily. It was necessary for her to work with other people who “continued to berate me and bad-mouth me.” The applicant says that she is constantly depressed and socially withdrawn. She is “constantly having flashbacks towards the treatment at work”.

43. In a supplementary statement dated 22 September 2020, the applicant addresses a payment of $1,129.25 which she received on 2 October 2019. She states that she commenced employment with Wilson Security on 2 August 2019, concurrently with her employment with the respondent, and worked for a period of one week. She did not receive payment for this week until 2 October 2019.

44. By a second supplementary statement dated 21 September 2020, the applicant addresses Dr George's opinion that there may be inconsistency arising from his observation that she took care with her appearance when she attended his rooms. The applicant states that this presentation is not always the case. She says that she "sometimes" tries to take care with her appearance. "These days it doesn't really matter to me how I look or how others perceive how I look".

45. The applicant reiterates that she suffers psychological symptoms including trouble with sleeping, constant flashbacks and "considerable difficulties with many aspects of my life." She also addresses the consultation with Dr Phillips in this way:

> "I note that in the psychological assessment, which I was very nervous about to begin with from Dr Phillips, concluded that I am presenting with evidence of malingering. Firstly, I wasn't even sure what this meant exactly and I needed to ask my lawyers about it. They told me that the conclusion was that I was pretending to be ill. I would like to confirm that this is definitely not the case."

DR KHAN

46. Dr Abdal Khan is the applicant's treating psychiatrist. He first saw her at the request of her general practitioner on 11 December 2019. He recorded a history consistent with the applicant's evidence of her experiences at work. He carried out a mental state examination which is recorded as follows:

> "Ms Massih presented as casually dressed with appropriate self-care. Rapport was established and there was no evidence of psychomotor disturbance. She described her mood in dysphoric terms with her affect appearing despondent. There were no abnormalities of speech or thought form. Ms Massih's thought content comprised trauma-related symptoms. Her cognition was grossly intact and she has had appropriate insight and judgement."

47. Dr Khan diagnosed post-traumatic stress disorder, prescribed medication, suggested ongoing psychological therapy and arranged for review in four weeks.

48. On 17 February 2020, Dr Khan noted an additional background factor, namely "tobacco use disorder". He recorded the following observations of the applicant:

> "She continued to experience ongoing trauma and depressive cognitions. Of particular concern was her low mood, irritability, agitation, nightmares and sleep disturbance. Her affect remained despondent."

49. Dr Khan discussed a change in the applicant's medication and stated that she was to continue to engage in psychological therapy.

50. Dr Khan saw the applicant again on 18 March 2020, 3 June 2020, and 8 July 2020, but despite medication and psychological therapy it is not apparent that there was any improvement in the applicant's condition.

DR RASTOGI

51. Dr Rastogi saw the applicant at the request of her solicitor on 15 May 2020 and provided a report on that date. The doctor obtained a history of bullying and harassment consistent with the applicant's evidence. Dr Rastogi recorded the following aspects of the applicant's complaints and presentation:

> "Her energy levels were poor and she had initial and middle insomnia. She was extremely irritable and anxious with constant ruminations. She lost her appetite and reported having constant nauseous episodes with chest pains and palpitations. She is dizzy and having panic attacks. She is preoccupied with the incidents and feels punished and targeted. She has always performed well and never been humiliated and denigrated like this. She reports short attention span and concentration lapses."

52. Dr Rastogi addressed the applicant's activities of daily living noting that the applicant needed prompting for many aspects of self-care, was reclusive and isolated, could not perform domestic chores which she had previously performed and had significant impairments of concentration, word-finding and decision-making.

53. On mental state examination, Dr Rastogi recorded the following:

> "Ms Massih was a thin-built woman with shoulder length hair who was distressed and very tearful. She looked tired and extremely drained. She was agitated and very upset. She maintained variable eye contact. Her speech was forthcoming and of normal rhythm and rate.
>
> Her mood was depressed and her affect was very tearful and distressed. She reported feeling distressed hopeless and worthless. Her self-esteem has been shattered and she has lost confidence."

54. Dr Rastogi diagnosed a major depressive disorder caused by her employment. Dr Rastogi commented:

> "She presents with physical symptoms of anxiety now that are quite debilitating and causing functional impairment.
>
> She remains unfit to work in any capacity due to psychological injury and has extreme poor stress tolerance."

55. Dr Rastogi expressed the opinion that the applicant would benefit from ongoing psychological therapy. She remained unfit for work and was "not ready for retraining or rehabilitation". By a supplementary report, she asserted that the applicant had 16% whole person impairment.

DR GEORGE

56. Dr Graham George, saw the applicant at the request of the respondent on 22 October 2019 and provided an initial report of 27 October 2019. He also recorded a history consistent with the applicant's evidence of her difficulties at work. He recorded a mental state examination as follows:

> "Mental state examination at the time of assessment revealed the woman, who was casually and neatly attired. She was around 160cm in height and about 60kg in weight. She related in quite an open fashion but appeared tense and anxious initially.

> Her affect was flat. She was tearful on a number of occasions. Her mood appeared depressed. Her thought form was normal and she did not exhibit any psychotic phenomena although she said that working in the environment in which she did and feeling somewhat persecuted she had a few paranoid ideas on occasions. However she did not have any delusional ideas as such. Her cognition appeared intact."

57. Dr George opined that the applicant suffered from major depression with anxiety. She should be treated with anti-depressant medication. Dr George thought that she presented with "a consistent history about bullying in the workplace and her symptoms are understandable in terms of what has occurred". Her employment was the main contributing factor to the exacerbation of her disease. She did not have any current earning capacity. He noted that the factual report offered some support for the applicant's account of events.

58. Dr George saw the applicant again on 30 June 2020 and provided a report of that date. The applicant told Dr George that she continued to be troubled by nightmares. On some days, she could not get out of bed and remained in her room most of the day. She only does small amounts of housework and refused the invitation of her siblings to go out.

59. Dr George recorded that the applicant has suicidal ideation in that if she had committed suicide "then she would not have to live the way she does". She described herself as "just useless".

60. Dr George recorded the following:

> "Her affect was tearful during the great majority of the interview. Her eye contact was intermittent. She looked down much of the time. She appeared distressed.
>
> Her mood appeared flat. There was no real reactivity to her mood state. She impressed as being depressed.
>
> Her thought form was normal. Her thought content revolved around nihilistic and negative themes. At times she said she does have suicidal ideation. She has not necessarily self-harmed, but on one occasion she said that she had punched her bedroom wall.
>
> She did not appear to be responding to any perceptual stimuli during the course of the interview and did not exhibit any psychotic phenomena.
>
> Generally her cognitions remained intact. However, she said that she struggles with attention, concentration and short-term memory recall."

Dr George then considered both the assessment of Dr Rastogi, which he stated was much like his own, and the report of Dr Phillips, which "provided convincing, objective, validated evidence to confirm his conclusion" of malingering. Dr George expressed the difficulties that confronted him as follows:

> "The quandary is that, on clinical examination, Ms Massih presents as suffering major depression. The concern in totally dismissing her clinical presentation is that, on this particular assessment, she revealed that she does have suicidal ideation. Also, she indicated feelings of worthlessness and hopelessness.

> On presentation, there were some contradictions noted due to the fact that she did take care with her appearance. This does not correlate with a severe depression. These contradictions place any clinical examiner in a double bind situation. On one hand, on clinical assessment, she presents with major depression and on the other hand, on psychometric evaluation, she presents with overwhelming evidence of malingering. In normal circumstances, I would accept Dr Phillips findings which totally negates a diagnosis of major depression."

61. In an attempt to resolve this quandary, he suggested that it may be useful to refer the applicant for further forensic psychological testing. He continued:

> "I would suggest that she undergoes a Trauma Symptom Inventory (TSI), a Test of Memory Malingering (TOMM) and the Miller Forensic Assessment of Symptoms Test (M-Fast). If all these tests demonstrate malingering then I believe it would be very difficult to maintain a case for a clinical diagnosis of major depression. Dr Phillips may or may not agree with carrying out these tests. His position might well be that there is no need for further testing."

62. Dr George also thought that the applicant should be referred to a mood disorders unit to assess her validity and to ascertain whether she, in fact, required more intensive treatment. He expressed the opinion that she would not return to working in a detention centre.

63. By a supplementary report of 3 August 2020, Dr George responded to an enquiry by the respondent's insurer, which asked him to assume that the treating practitioners did not believe that the applicant exhibited suicidal ideation, by the following:

> "Given the opinions which you have sourced and also, the conclusion of Dr Phillips, my general assessment is that in the absence of results of forensic psychological testing, I am unable to hold my clinical opinion of major depression with any confidence. The opinion of Dr Phillips cannot be ignored."

Dr Rastogi - 5 October 2020

64. By a supplementary report dated 5 October 2020, Dr Rastogi addressed the opinions of Dr Phillips and Dr George. She asserted that the validity and accuracy of the Minnesota Multiphasic Personality Inventory 2 (MMPI-2) was "questionable given it is self-reported". She stated that "history, symptomatology and examination needs to be incorporated rather than relying on self-administered scores."

65. Dr Rastogi continues that MMPI-2 is not a valid measure of a person's psychopathology or behaviour if the person taking the test does so in a way that is not honest or frank. She notes that the applicant has seen several psychiatrists and psychologists following the cessation of her employment all of whom had diagnosed a psychological/psychiatric condition. The opinion of these specialists should not be overridden by the MMPI.

66. Dr Rastogi also expressed the opinion that Dr George had not given any plausible and fair explanation for this change of opinion given his previous reports in which he had opined that the applicant suffered from major depressive disorder. She concluded by stating:

> "I do not agree with his opinion or Dr Phillips' opinion who have not taken a comprehensive outline of the condition and made assessment based on reviews and MMPI that are not valid and reliable and are biased opinions."

DR KHAN - 18 September 2020

67. By a supplementary report dated 18 September 2020, Dr Khan also commented on the opinions of Dr Phillips and Dr George. In respect of the psychometric testing carried out by Dr Phillips he said this:

> "The fact that Dr Phillips relies on a rudimentary assessment process without appropriately considering the presentation of Ms Massih and the contemporaneous medical records of Ms Massih raises questions about the credibility and validity of his assessment. Malingering is an assessment that can only be concluded based on clinical and non-clinical information. Dr Phillips has not commented on any non-clinical information that would indicate Ms Massih is malingering. Interestingly, Dr Phillips is an allied health practitioner whose opinion is incongruent with numerous medical practitioners who all acknowledge that Ms Massih suffers psychiatric/ psychological condition."

68. Dr Khan also expressed his disagreement with the opinion and reasoning of Dr George. He thought that the applicant's history was not suggestive of malingering. He expressed the opinion that Dr George's questioning of his initial medical opinion based upon "the rudimentary assessment conducted by Dr Phillips" was concerning.

DR PHILLIPS

69. Dr Phillips saw the applicant on 5 June 2020 and provided a report which is 44 pages long. He had available to him the reports of the psychiatrists and general practitioners who have treated the applicant or provided reports for the purposes of this litigation. He also had a copy of the factual report of Procare dated 27 September 2019. He also took a history of the applicant's current mental and bodily health and carried out a mental state examination.

70. Dr Phillips administered three psychometric tests, the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), the Personality Assessment Inventory (PAI), and the Structured Inventory of Malingered Symptomatology (SIMS).

71. Dr Phillips considered the theory that clinical examination was likely to be more accurate than the testing regime he performed on the applicant. He stated that the last 70 years of research had established that testing was superior to the clinical interview in determining psychological illness. He gives several examples where psychiatrists have accepted various forms of psychological illness on interview, but their patients were subsequently revealed to be dissembling. He asserts that studies have demonstrated that objective assessment instruments are significantly more accurate than clinical judgement.

72. Some aspects of Dr Phillips report are opaque. It is apparent, however, that the testing undertaken by the applicant was performed in the manner described below:

> "Each person is asked the same question in the same order. The person chooses their response and the software converts these to a score on the relevant scale. Each scale within the test measures a specific quality, e.g. depression, anxiety, trauma etc. When using the copyright owner software for input, initial analysis and report production, this is a sealed black box. The tests were administered on an iPad or personal computer. The assessor cannot interact with or alter this process.
>
> It is important to note that any assessor would be given the same scores from the software if the data entered by the injured worker was the same and if they used the same published cut-points the interpretation would be the same, i.e, if the injured person answers the same, the scores and their interpretation is the same and independent of the assessor's opinion.

Further expertise is then required to use a triangulation process to synthesise the multiple reports from the various tests and the numerous scales within each test together into a coherent diagnosis. Triangulation is a process whereby multiple types and sources of data are synthesised to perform an error eradication process. There are four different types of triangulation and all are present in this process."

73. Dr Phillips states that neither the questions which are utilised for psychometric testing nor the patients answer to the questions are made available to others. However, he reported the findings of the testing as follows:

> "She exceeded cut-off for potentially malingering on 21 of the 21 scales. The finding of a genuine mental illness is excluded as the person is endorsing fictitious symptoms; symptoms that are inconsistent with genuine psychiatric patients; exaggerated symptoms; unusual somatic complaints that are unlikely in genuinely mental ill people; and unusual memory and cognition complaints that are not accountable for even by sustaining a brain injury. Based on her own responses to the testing administered, one cannot reliably accept she suffers any psychological illness as defined in the diagnostic and statistical manual. Taking the least reliable scale, the Affective Disorders scale of the SIMS, which has a false positive rate of 30%, failing 21 scales represents a probability lower than 0.0000000116226% chance of false positive finding of malingering. This means that not only can malingering not be ruled out as per the handbook of differential diagnoses, it must be considered to be ruled in."

74. Dr Phillips gives a number of examples where the applicant gave wrong answers to questions which were generally answered correctly by patients with amnesia, low intellectual capacity, genuine brain injuries or severe psychological or neurological illness. Thus, there was "gross inconsistency between self-report and test results".

DISCUSSION AND FINDINGS

75. I do not accept Mr Tanner's submission that Dr George's opinion in his report of 3 August 2020 is based on a false assumption that the applicant did not suffer from suicidal ideation. There is sufficient evidence contained in the email responses to the respondent's insurer from Ms Tang, a psychologist, and Dr Khan to negative recent suicidal ideation. Dr Khan stated that the applicant had "never expressed active suicidal ideation or intention to him" during his consultations.

76. Conversely, I believe there is considerable force in Mr Tanner's submission that Dr George did not abandon his opinion that the applicant suffered major depression in his final report. Rather, he thought that, in the absence of further psychometric testing, he could not hold to it with any confidence. On the other hand, it is undoubtedly the case that he accepts that psychometric testing is a valid and efficacious tool in reaching or excluding a psychiatric diagnosis.

77. Unfortunately, neither Dr George nor the applicant's treating, or qualified psychiatrist provide a methodical or readily digestible explanation as to why psychometric testing in general and the specific psychometric testing in this case should be accepted or rejected by psychiatrists and, ultimately, by the Commission. By contrast Dr Phillips devotes many pages of his report to arguing the efficacy of the psychometric testing and its widespread use in government and industry.

78. Dr Rastogi states that psychometric testing needs to be incorporated into history taking and clinical observations but does not attempt to do this. As Mr Beran argued, Dr Rastogi does not engage with the testing or provide an explanation of her response. She states that self-administered psychometric testing provides little insight as to diagnosis when a patient does not engage with it in an honest and frank manner. It is not clear whether she is suggesting that the applicant did not perform the tests administered by Dr Phillips in an honest and frank manner.

79. Dr Khan provides a more reasoned critique of the psychometric testing, which I am inclined to accept for reasons which I will elaborate on below. However, Dr Khan provides only a slight argument as to why the tests lack validity. He states that malingering can only be diagnosed on a combination of the clinical and nonclinical evidence. It is apparent that he believes that the tests can be entirely discounted in favour of a diagnosis based upon history taking and mental state examination. He does not deal with the obviously plausible argument as to the frailty of observation and mental state examination contained in Dr Phillips' report.

80. The paucity of the arguments from the three psychiatrists as to the efficacy of psychometric testing may be partly attributable to the absence of oral medical evidence in the case. None of the psychiatrists were required to fully explain their respective positions with respect to psychometric testing. I appreciate that there are costs restraints in workers compensation matters. However, it is regrettable that a complex issue such as this is not addressed by the doctors in a more ample fashion.

81. Another difficulty is that psychometric testing is a mysterious process. It remains so despite the many pages of argument produced by Dr Phillips as to its value. It is difficult to adequately evaluate the validity of the opinion of Dr Phillips by reference to the contents of his report. That is because the questions asked of the applicant and her replies are undisclosed and the process of "triangulation", which is fleetingly addressed by Dr Phillips, is not exposed so that the study of the process cannot easily lead a tribunal to be comfortably satisfied of its efficacy.

82. in *Brighten v Traino* [2019] NSWCA 168 (*Brighten*) at [79], Basten JA described the results of psychometric testing, including the Minnesota Multiphasic Personality Inventory Test performed by Dr Phillips in this case, as "impenetrable". In that case, the author of the test, Dr Lee, a psychiatrist, gave oral evidence. While I do not presume that there is any similarity between the medical evidence in that case and the present, the Judge's description of the testing is a concise summary of my opinion.

83. In *Makita (Australia) Pty Ltd v Sprowles* 52 NSWLR 705 Hayden JA, as he then was, observed that for the report of Professor Morton, a physicist, to be useful "it was necessary for it to comply with a prime duty of experts in giving opinion evidence: to furnish the trier of fact with criteria enabling evaluation of the validity of the expert's conclusions." He quoted with approval the statement of Lord President Cooper in *Davie v the Lord Provost, Magistrates and Counsellors of the City of Edinburgh* 1953 SC 34 at 39-40, which is indelibly stamped on the mind of personal injury lawyers in New South Wales because of its conclusion that in embarking upon litigation the parties have " invoked the decision of a judicial tribunal and not the oracular pronouncement of an expert."

84. In *Brighton* Basten JA referred to several questions that had formed part of psychometric evidence as a "seriously disturbing material". In the absence of evidence as to their character, it is not possible to make any comment on the process in this case. I note, however, that on 10 June 2020 the applicant stated to her general practitioner that she found the four-hour assessment tiring and that she was nauseated throughout.

85. On 15 June 2020, a psychologist recorded the following at a telehealth appointment:

> "Two weeks since seeing insurance psychologist triggered a lot of stress during a 5 hour assessment. Was asked 'if she saw green monsters', felt scared by comments and did not understand the process or purpose of assessment. Reported being very fatigued on this day. Anxiety and fear in relation to returning to work. Highly Anxious - client is distressed as she is anxious and wants to recover. Tearful in session when describing assessment that occurred with insurer. Began shaking as she described experience with the insurer."

86. I am not able to find that the report of Dr Phillips standing alone is of value. It follows that I am largely reliant on the terse and unsatisfactory opinions of the specialist psychiatrists as to the cogency of the psychometric testing. As I have indicated, Dr Rastogi has rejected the testing, but her reasoning is obscure. Dr George no longer confidently holds the opinion that the applicant has a major depression, although he does not categorically reach the conclusion that the applicant is malingering. It is likely that he requires further testing to resolve his dilemma. Dr Khan gives brief but logical reasons why he discounts the psychometric testing in favour of his diagnosis. I conclude that, collectively, the three psychiatrists in the case express significant reservations as to the validity of the psychometric testing.

87. If there is a significant conflict in the medical evidence, I prefer the evidence of Dr Khan who has had the opportunity to see the applicant on several occasions and is in the best position to offer an opinion as to whether she was dissembling or suffered from a recognisable psychiatric condition in 2019.

88. But there are other reasons why it is appropriate to find psychological injury in this case. Even if the psychometric testing was determinative of the applicant malingering in June 2020, that does not necessarily undermine the applicant's case that she suffered a psychological injury in August 2020. There are aspects of the evidence which, in my opinion, establish this as a probability.

89. First, as Dr George observes, the circumstances of the applicant's employment, which are undisputed, are undoubtedly of a type that might cause psychological injury. I have often criticised the use of the phrase bullying and harassment as a description of the activity allegedly giving rise to psychological injury. However, in this case there is a history of intense bullying and harassment which persisted over some months.

90. Secondly, as Dr Khan observes, the applicant continued to work despite the harassment and indeed found other employment in August 2019, when she reached the conclusion that she could no longer work for the respondent. It is true that the applicant only worked for one week in that employment. But the history is not consistent with malingering.

91. Thirdly, there is the complete unanimity opinion in 2019, among several medical practitioners and allied health professionals, that the applicant had a psychological injury. I appreciate the argument advanced by Dr Phillips that appearances can mislead and that psychiatric patients dissemble when interviewed for clinical examination . However, as I am unable to unreservedly accept Dr Phillips' opinion, I am not persuaded on the balance of probabilities that the applicant successfully feigned psychiatric injury at presentation with medical practitioners in 2019. On the contrary, the evidence establishes the occurrence of a psychological injury.

92. In those circumstances I propose to find that the applicant suffered psychological injury arising out of and in the course of her employment with the respondent deemed to have occurred for the purposes of the 1987 Act on 29 August 2019. In the circumstances of this case, the question of whether the psychiatric injury was transient or permanent, and the implications of the psychometric testing for the determination this issue can be dealt with by an Approved Medical Specialist. A psychiatrist will have a far greater appreciation of the value of the psychometric testing than an arbitrator by reason of his training and experience. Further, he will be able to carry out or require further testing if that is appropriate.

93. While I accept that it is open to an arbitrator in determining an entitlement to weekly compensation for medical expenses to make a finding that the effect of an injury has ceased or alternatively has continued to the present, as Mr Beran submitted, that is not an appropriate course of action in the unusual circumstances of this case.

94. I propose to ask the Approved Medical Specialist to state his reasons for accepting or rejecting the psychometric testing in determining the issue of the permanency of the applicant's condition.

95. On receipt of the MAC, I propose to appoint a telephone conference to ascertain whether the parties wish to further litigate the issue of weekly compensation and medical expenses. If necessary, I will also make orders in respect of cross-examination of the applicant on these issues at the telephone conference.

96. I find that the applicant suffered psychological injury in the form of a major depressive disorder arising out of and in the course of employment with the respondent which is deemed to have occurred on 29 August 2019.

97. I remit the matter to the Registrar for referral to an Approved Medical Specialist to certify the degree, if any, of the whole person impairment as a result of the injury.

98. I stand the issues of weekly payments and medical expenses over to a telephone conference after the receipt of the MAC.