WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1612/19**
Applicant: **TODD TRAYNOR**
Respondent: **AMP SERVICES PTY LIMITED**
Date of Determination: **23 July 2019**
Citation: **[2019] NSWWCC 251**

The Commission determines:

1. That the Application to Resolve a Dispute for section 66 of *Workers Compensation Act 1987* (the 1987 Act) lump sum compensation for deep vein thrombosis injury is discontinued.

2. That the respondent pay the applicant's section 60 of the 1987 Act expenses for deep venous thrombosis injury on 30 June 2016 on production of accounts/receipts.

3. Award in favour of the respondent in respect of the claim for primary psychological injury.

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

Ross Bell
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 ROSS BELL, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

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Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. This Application to Resolve a Dispute is in respect of claims for injury of Deep Vein Thrombosis (DVT); and associated primary psychological injury on 30 June 2016. The insurer denied the claim in a notice dated 11 October 2016. At the conciliation and arbitration hearing the application for section 66 of the *Workers Compensation Act 1987* (the 1987 Act) lump sum compensation in respect of DVT was discontinued.

ISSUES FOR DETERMINATION

2. The following issues remain in dispute:

    (a) Whether Mr Traynor suffered injury of DVT arising out of or in the course of his employment with AMP Services Pty Limited (the respondent) (s 4(a) of the 1987 Act; or in the alternative,

    (b) Whether Mr Traynor suffered a disease of gradual process in the form of DVT; or the aggravation, acceleration, exacerbation or deterioration of a disease (s 4(b)(i) or 4(b)(ii) of the 1987 Act;

    (c) If so, whether the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration (s 4(b)(i) or 4(b)(ii) of the 1987 Act);

    (d) Whether Mr Traynor suffered primary psychological injury arising out of or in the course of his employment with the respondent on 30 June 2016 (s 4; s 65A of the 1987 Act;

    (e) If so, whether his employment was a substantial contributing factor to the injury (s 9A of the1987 Act);

    (f) Whether that injury was a “secondary psychological injury”;

    (g) Is Mr Traynor entitled to be assessed pursuant to for lump sum compensation? (s 66 of the 1987 Act), and

    (h) whether Mr Traynor is entitled to s 60 of the 1987 Act medical expenses for the claimed injuries.

PROCEDURE BEFORE THE COMMISSION

3. The parties attended a conciliation conference and arbitration hearing on 2 July 2019. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Oral evidence

4. There was no oral evidence adduced.

Documentary evidence

5. The following documents were in evidence before the Commission and I have taken them into account in making this determination:

    (a) Application to Resolve a Dispute with annexed documents, except the reports of Dr R Hampshire and Dr S Stylion which are excluded.

    (b) Reply with annexed documents, except the reports of Dr J Niesche which are excluded.

    (c) Application to Admit Late Documents filed for the respondent dated 15 May 2019 with email and employment records.

    (d) Application to Admit Late Documents filed for Mr Traynor dated 24 June 2019 with his supplementary statement dated 9 May 2019; and report of Dr Ackroyd dated 17 May 2019.

    (e) Application to Admit Late Documents filed for the applicant dated 23 April 2019 with list of medical expenses; and updated clinical notes of Ocean Shores Medical Centre.

Did Mr Traynor suffer personal injury in the form of Deep Vein Thrombosis out of or in the course of his employment with the respondent on 30 June 2016 under s 4(a) of the 1987 Act; or alternatively a disease; or the aggravation, acceleration, exacerbation or deterioration of a disease under s 4(b) of the 1987 Act?

6. In his statement of 30 September 2016, Mr Traynor says that in the period leading up to the formation of the DVT he was working what he describes as “long hours” in front of a work computer in the order of 50 to 60 hours per week at a busy time of year in his employment. He says the long periods sitting at the computer in his work-from-home arrangement with the respondent were made longer by a slow internet connection issue.

7. The respondent submits that the employer’s work log records demonstrate that the history given by Mr Traynor in his statements is incorrect. It submits also that the history taken by Dr Ackroyd that Mr Traynor worked 16 hours on 30 June 2016 was also incorrect. There is an email from Roxanne McGregor dated 7 October 2016 with attached work hours. This shows approximately 6.5 hours logged on to the employer’s system on 30 June; 6.2 hours on 29 June; 7.5 hours on 28 June; and 7 hours on 27 June. The hours worked for the rest of June were of the same order, except for a break from 9 June to 16 June.

8. Mr Traynor outlines in his statement of 9 December 2018 the events following the onset of pain in the calf which led to the diagnosis of DVT. Dr Ackroyd takes a history that,

> “On 30 June 2016, he was working from home and noticed a pain in his right leg. He notes this date, being the end of the financial year, is the busiest of the year for his type of work and he had been sitting at his computer for nearly 16 hours on this occasion.
>
> Prior to this he had made two visits to Brisbane to Head Office by car on the two days prior to the DVT.”

9. Dr Ackroyd also reports,

> "Prior to the DVT event he had been working long hours for the three months beforehand. This was exacerbated by having a computer that was too slow and consequently he needed to work at his desk for longer hours."

10. Dr Ackroyd concludes under "Opinion",

> "He developed a right lower limb DVT following a long period of immobility working at his desk from home while in the employ of the AMP.
>
> This DVT subsequently embolised to his lung and may have been associated with a small area of pulmonary infarction."

11. The respondent submits that Dr Ackroyd's opinion is diminished by the incorrect history he reports and his conclusion is based on the history he took of 16 hours immobility at his desk before the DVT event on 30 June 2016, and on the general history that Mr Traynor had been working long hours in the period leading up to the DVT. In my view the incorrect history does diminish the value of Dr Ackroyd's opinion. Dr Ackroyd also does not take the history of Mr Traynor waking on 30 June 2016 with the symptoms of DVT. He reports, "On 30 June 2016 he was working from home and noticed a pain in his right leg."

12. It seems to me that the sequence of events was that Mr Traynor woke on the morning of 30 June 2016 with pain in his calf, as noted in the clinical notes of Dr Murphy for 5 July 2016, "woke with severe right calf pain last week …". This pain then worsened during the day.

13. Dr Jander took the history that,

> "He stated that he woke up in the morning, felt pain in the back of the calf and he has continued to work from home. At about lunch time the pain became excruciating and he felt like he had a golf ball in the back of his leg. He went to his doctor, Dr Warwick Benson, who felt that it might be a clot and he was referred the next day for an appointment."

14. Dr Jander also reports,

> "He was seen by Dr Lee who investigated him further and has been managing his condition. The key factors were that he had the clot behind the knee and had been working in the seated position for quite a stressful period of time. He stated he had been working for prolonged periods of time."

15. Dr Jander's opinion is that,

> "I would believe that the main contributing factor to Mr Traynor's deep vein thrombosis was his elevated homocysteine level combined with a level of inactivity not necessarily related to his work. Therefore the main contributing factor was the elevated homocysteine and low folate levels."

16. Dr Jander was asked the following question by the insurer,

> "If Mr Traynor was working from home at the said time of developing a DVT is it likely that he remained immobile for a very long time? (we note that his Treating Doctor Dr Sarah Morrison- Gardiner 21 September 2016, (dot point third from bottom) states ... " It is less likely this would have occurred at home ... ,' Can you comment on this please?"

17. Dr Jander answered,

> "Whether he was working from home or he was working from an office, I believe would have been irrelevant to the fact this condition was likely to have occurred in any period of stasis, i.e. he could have been sitting in front of the TV at the time that it occurred so I do not believe that occupation was the significant contributing factor to this inactivity. It may have been a contributing factor but the main contributing factor was the elevated homocysteine levels. The main contributing factor to his condition is as noted in the report from Dr Lee dated 6 August 2016 is his elevated homocysteine levels."

18. When considering the background issue of the raised homocysteine level and low folate, the "eggshell skull principle" and the concept that "employers take their employees as they find them" is to be recognised.[1] Any vulnerability or pre-disposition may be relevant under section 9A of the 1987 Act.

19. Dr Jander was also asked about other medical conditions such as knee injuries or BMI likely to be contributing factors to blood clots. She refers to a separate left knee injury in December 2015 which was being treated by Dr M Graze as he reported on 20 August 2016. Dr Graze notes the restrictions from the knee, including an inability to go jogging or to walk on the beach.

20. Dr Jander responded,

> "His elevated homocysteine levels and level of inactivity and deconditioning related to his left knee injury which occurred in December. This has resulted in him performing less physical activity in his day to day life and therefore he had gained weight."

21. The respondent submits that the DVT should be taken to be a disease, or the aggravation, acceleration, exacerbation or deterioration of a disease, and not a single incident of injury.

22. The previous DVT episode of approximately 20 years beforehand occurred when Mr Traynor had his leg immobilised in plaster due to a left knee injury. He says of the incident,

> "20 Years ago, I injured my left knee playing rugby league. At the time, I dislocated my left patella. I developed a blood clot in my leg as a result of the trauma. I was placed in a temporary cast and immobile, and then after three days a clot formed. I was monitored as an impatient at Liverpool Private Hospital for one week and placed on Warfarin. At that time my general practitioner was Dr Chiew, care of Ingleburn Medical Centre. I recovered completely from that incident and I had no further issues until 30 June 2016."

23. The High Court in *Zickar v MGH Plastic Industries Pty Ltd* [1996] HCA 31 observed that the terms "disease" and "personal injury"in s 4 are not mutually exclusive. The Court confirmed in *Military Rehabilitation and Compensation Commission* v *May* [2016] HCA 19 that there can be overlap between a disease and a personal injury,

> "45. 'Injury' in par (b) is used in its 'primary' sense. As Gleeson CJ and Kirby J explained in Kennedy Cleaning Services Pty Ltd v Petkoska, if 'something ... can be described as a sudden and ascertainable or dramatic physiological change or disturbance of the normal physiological state, it may qualify for characterisation as an 'injury' in the primary sense of that word' (emphasis added).

[1] *State Transit Authority of NSW v Fritzi Chemler* [2007] NSWCA 249; *Attorney General's Department v K* [2010] NSWWCCPD 76

46. That physiological change or disturbance of the normal physiological state may be internal or external to the body of the employee. It may be, for example, the breaking of a limb, the breaking of an artery, the detachment of a piece of the lining of an artery, the rupture of an arterial wall or a lesion to the brain. Each would be described as an 'injury' in the primary sense.

47. However, as the Full Court correctly held, 'suddenness' is not necessary for there to be an 'injury' in the primary sense. A physiological change might be 'sudden and ascertainable'. A physiological change might be 'dramatic'. The employee's condition might be a 'disturbance of the normal physiological state'. That an 'injury' in the primary sense can arise, and can be described, in a variety of ways does not mean that 'suddenness' is irrelevant. As the Full Court said, 'suddenness' is often useful where there is a need to distinguish a physiological change from the natural progress of an underlying (and in one sense, closely related) disease (as occurred in Zickar v MGH Plastic Industries Pty Ltd and Kennedy Cleaning). But it is the physiological change – the nature and incidents of that change – that remains central.

48. That an 'injury' in the primary sense can arise, and be described, in a variety of ways was recognised by Gleeson CJ and Kirby J in Kennedy Cleaning when their Honours stated:

> '[C]onsideration [must] be given to the precise evidence, on a fact by fact basis, concerning the nature and incidents of the physiological change accepted at trial. If this evidence amounts, relevantly, to something that can be described as a sudden and ascertainable or dramatic physiological change or disturbance of the normal physiological state, it may qualify for characterisation as an 'injury' in the primary sense of that word.' (emphasis added)'"

24. Applying these principles to the facts of this matter, it seems to me that the physiological event for Mr Traynor was a personal injury. The thrombosis developed over a relatively short period overnight, and comprised a "sudden and ascertainable or dramatic physiological change or disturbance of the normal physiological state" resulting in the pain symptoms. There was no "disease" of DVT stretching from the event 20 years ago to the present or commencing at some point prior to the June 2016 DVT. The earlier event also required the additional factor of an immobilised leg for the DVT to occur.

25. Dr Morrison-Gardiner says in her short report of 21 September 2016, "it is less likely this would have occured at home, as there is more potential for movement, elevation of limbs etc., then there is at a stationary work desk." Dr Jander, when asked about this opinion, said any form of inactivity could have casued the DVT, incuding sitting in front of the television. The work "may have been a contributing factor" but the chemical imbalance was "the main contributing factor" to the DVT.

26. Dr Jander also says the DVT was partly caused by inactivity "not necessarily related to his work". It is apparent from the evidence, including Dr Jander's report, that immobility or "period of stasis", as she puts it, is a causative factor for those with a pre-disposition for DVT like Mr Traynor. Mr Traynor was sitting at his work desk for the periods shown in the employer's log discussed above in the days before the clot appeared.

27. For an injury to arise out of the employment requires "a certain degree of causal connection between the accident and the employment"[2]. The employment must to some material extent contribute to the injury. I am satisfied that Mr Traynor's immmobility sitting at the work computer for the hours shown in the employer's log satisfy this test.

[2] *Badawi v Nexon Asia Pacific Pty Ltd t/as Commander Aust Pty Ltd* (2009) NSWCA 324

28. For these reasons I find that Mr Traynor suffered the injury of DVT out of his employment with the respondent, pusuant to s 4(a) of the 1987 Act. The DVT was not a disease, or the aggravation, acceleration, exacerbation or deterioration of a disease.

Was the employment a substantial contributing factor to the DVT injury?

29. Dr Jander, as extracted above, believes that, in addition to "immobility not necessarily related to his work" the "main contributing factor" to the DVT was the elevated level of homocysteine and the low folate level, plus the additional inactivity due to the left knee injury from December 2015. The test for section 9A of the 1987 Act is whether the employment was "a substantial contributing factor", not "the main contributing factor".

30. There are clearly factors other than the employment contributing to the DVT. The (non-exhaustive) examples in section 9A(2) of the 1987 Act are,

> "(a) the time and place of the injury,
> (b) the nature of the work performed and the particular tasks of that work,
> (c) the duration of the employment,
> (d) the probability that the injury or a similar injury would have happened anyway, at about the same time or at the same stage of the worker's life, if he or she had not been at work or had not worked in that employment,
> (e) the worker's state of health before the injury and the existence of any hereditary risks,
> (f) the worker's lifestyle and his or her activities outside the workplace"

31. Mr Traynor was largely immobile due to his work for the hours each day recorded in the employer's logs. The DVT occurred overnight on a Thursday after four sedentary days of work.

32. It cannot be said that the injury would have occurred anyway, because in addition to the predisposition due to chemical imbalances found by Dr Lee, more was involved in periods of immobility for the DVT to appear. Dr Jander refers to this factor when citing immobility issues including the recurrent left knee restrictions.

33. Mr Traynor had an issue 20 years beforehand, but no DVT episodes after that up to 2016. There was a congenital factor in the abnormal chemical levels, but this was insufficient in itself to cause the DVT. The decrease in his general activity levels due to the left knee problems from the end of 2015 is considered by Dr Jander as a contributing factor, but this hindrance was not immobilising to the extent of the "stasis" of sitting in front of the computer for the duration of each working day.

34. There is no evidence that Mr Traynor undertook sedentary activites at home involving long periods of immobility.

35. The relevance of periods of immobility in his work to the type of injury he suffered gives the overall impression that it is a real factor of substance among the other factors.

36. For these reasons I find that Mr Traynor's employment was a substantial contributing factor to the DVT injury on 30 June 2016.

Did Mr Traynor suffer primary psychological injury out of or in the course of his employment with the respondent on 30 June 2016?

37. The sequence of events following the emergence of symptoms in the calf on 30 June 2016 was that Mr Traynor called the respondent's in-house chief medical officer who said it might be a blood clot and should be checked. Mr Traynor then contacted his general practice at Ocean Shores and made an appointment for the following Tuesday (apparently 5 July 2016). Dr M Murphy referred him for an ultrasound on his calf. Mr Traynor attended Byron Bay Hospital for this service, which confirmed the blood clot. The following day, 6 July, Mr Traynor returned to the Ocean Shores practice where he consulted his usual general practitioner, Dr Morrison-Gardiner, who informed him he had a 12 centimetre DVT in the right leg, and prescribed Clexane, a blood thinner.

38. On 8 July, Mr Traynor woke with pain in his chest. He states "I was terrified", and he attended Byron Bay Hospital's emergency department. He was given morphine and a scan was taken. The hospital suspected a chest infection and he was discharged. The next morning, 9 July, Mr Traynor received a call from the hospital informing him he had clots in his lungs and he should see his general practitioner urgently. He saw Dr Morrison-Gardener the same day.
He did not wish to go back to Byron Bay Hospital so MrTraynor's wife drove him to Tweed Heads Hospital where he was admitted for seven days and treated with Clexane twice per day.

39. Mr Traynor describes being discharged from the hospital on 14 July 2016, and being treated with Clexane each day for a year. He describes difficulties walking, shortness of breath, headaches, and feeling confused and disoriented. He states, "I have significant issues with severe depression and anxiety." On 22 July 2016, Dr Morrison-Gardiner referred Mr Traynor to Natalie Isbister, psychologist, and on 8 November 2016 to Dr McDornan, psychiatrist, who he has continued to treat him on a regular basis.

40. From paragraph 57 of his statement Mr Traynor outlines the "Impact on life". He says that since the DVT on 30 June 2016 he finds life difficult. He does not leave the house unless necessary, and has stopped the enjoyment of family holidays and involvement in the sporting activities of his children. He was a keen surf life saving and beach activities participant but no longer engages in that. He says he feels he has let his children down, and he feels low all the time, and there are financial difficulties.

41. The clinical notes of Mr Traynor's local medical practice record reference to psychological elements. The entry for 5 July 2016 records the DVT symptoms. On 11 July, Dr Morrison-Gardiner noted the appearance of lung clots. On 18 July the record includes, "also signs of depression", and on 22 July, the referral to the psychologist was made.

42. The submisison for Mr Traynor is that it was the shock of being told about the lung embolism after the initial mis-diagnosis by Byron Bay Hospital that caused his depression, and that this is a primary psychological injury.

43. Section 65A defines the two types of psychological injury,

> "(5) In this section:
> 'primary psychological injury' means a psychological injury that is not a secondary psychological injury.
>
> 'psychological injury' includes psychiatric injury.
>
> 'secondary psychological injury' means a psychological injury to the extent that it arises as a consequence of, or secondary to, a physical injury."

44. The Minister's Second reading speech on s 65A explained the intention,

> "The provisions are limited to those suffering a primary psychological injury, that is, a psychological injury that arises directly from an event in the workplace – such as an armed hold-up or violent assault – rather than as a consequence of or secondary to a physical or other injury."

45. Dr Gertler in his report of 19 June 2018 takes the history of the mis-diagnosis followed by the call from the hospital about the lung embolus. He then notes,

> "Over subsequent months Mr Traynor became increasingly depressed. He felt guilty that he was not able to work and to support his family. He submitted a worker's compensation claim which was rejected and he received no support at all from his employer.
>
> As Mr Traynor's depression became worse he began isolating himself and staying in his room. He was referred to a psychologist later in 2016 and also commenced on anti-depressant medication."

46. Dr Gertler goes on to give his opinion as to casuation,

> "The major depression is a primary psychological injury which has in my opinion developed on the basis of the deep venous thrombosis on 30 June 2016, subsequent development of serious pulmonary embolus and ongoing physical disability with an inability to return to any form of employment. This' has led to difficulties within the home, feelings of uselessness and helplessness as well as ultimately, suicidal ideation."

47. Dr Gertler also opines,

> "Mr Traynor's employment. the development of the deep venous thrombosis and subsequent pulmonary embolus, was in my opinion a substantial contributing factor to the development of the major depression."

48. Dr Lotz differs from the view of Dr Gertler,

> "I concur with Dr Gertler that his current psychiatric symptoms would be calculated to be a 19% WPI. However as noted above, in my opinion the psychological condition is a secondary psychological injury to his DVT. I note as per paragraph 1.22, page 5 of the NSW workers compensation guidelines for the evaluation of permanent impairment 4th ed, that ' ... No permanent impairment assessment is to be made of secondary psychiatric and psychological impairments ... '. Therefore, I do not believe it is appropriate to assess impairment for his psychological condition as in my opinion all of his psychiatric injury is secondary to the DVT of June 2016. There did not appear to be a pre-existing psychiatric nor psychological injury prior to June 2016.

49. The comments of Dr McDornan as treating psychiatrist are of interest on this issue. In his report of 29 November 2016, Dr McDornan summarises the history of the onset of symptoms, the diagnosis, and early treatment. He goes on to note that,

> "Since this time Mr Traynor has descended into a clinical depression with a significantly lowered mood without diurnal variation. He reports a loss of humour. Previously he was interested in surf lifesaving and this has completely gone. He had become much more avoidant socially. …
>
> Mr Traynor reports an array of moderate to severe depressive features regarding his thinking. He added 'I feel stupid ... l get scared'. His self-view was one of self-depreciation and guilt over his inability to provide for his family. His future· view was limited and 'pretty worried', and he highlighted a sense of futility and indifference to life, without a clear and active suicidal plan."

50. Under "Diagnosis" Dr McDornan says,

> "Mr Traynor's depression seemed secondary to his health decline and a sense of loss of role as well as difficulties in how he interprets the WorkCover system as he transfers through this. Whether there is some organic contribution from a minor cerebrovascular event is yet to be determined although the association with pulmonary embolism is not robust at all."

51. It is submitted for Mr Traynor that the circumstances of his psychological injury are analogous to those in *RSL (QLD) War Veterans Homes Ltd v Watkins* [2013] NSWWCCPD 44 (*Watkins*), the outcome of which was confirmed by Deputy President Roche on appeal from my arbitral determination. I do not accept this submission. Ms Watkins was diagnosed with Post Traumatic Stress Disorder and the evidence was of a direct link between the event of her fall and the psychological condition. The features of the condition, including flashbacks and nightmares about the fall itself, phobias about people walking on uneven ground, and high heeled shoes were compelling in establishing a primary psychological injury. None of those factors are present in Mr Traynor's circumstances on the evidence.

52. The applicant also relies on *Sydney South West Area Health Service v Dyer* [2012] NSWWCCPD 46 but this case of little assistance as the facts and issues are quite different to those in this matter.

53. Dr Gertler's opinion is that the major depression is a primary psychological injury. I prefer the opinion in particular of Dr McDornan and also of Dr Lotz on the question, because there is a lack of evidence to support a primary link. There are no indicators of ongoing impact of the shock of the appearance of DVT and resulting pulmonary embolus in Mr Traynor's presentation. He says in his statement that he was "terrified" when he got pains in his chest, but there is no evidence that would direct the conclusion of a primary psychological injury arising from this, as there was, for example, in *Watkins*. Mr Traynor's statement itself is generally consistent with Dr McDornan's view as to the condition being secondary to "… his health decline and a sense of loss of role…" There is no insistent presence of the shock of the DVT and embolism visible as the cause of the psychological disorder.

54. For these reasons I find that Mr Traynor suffered psychological injury secondary to the DVT, but did not suffer primary psychological injury. He is therefore precluded from being referred for assessment for s 66 of the 1987 Act lump sum compensation for psychological injury on 30 June 2016.

Section 60 of the 1987 Act medical expenses

55. It follows from the above findings that Mr Traynor is entiled to be paid his medical expenses for the DVT injury.

SUMMARY

56. Mr Traynor suffered personal injury of DVT on 30 June 2016 pursuant to s 4(a) of the 1987 Act.

57. There is to be an order for s 60 of the 1987 Act expenses for the compensable DVT injury.

58. Mr Traynor suffered a secondary psychological injury in terms of section 65A of the 1987 Act, but not a primary psychological injury.

59. There is to be an award in favour of the respondent in respect of the alleged primary psychological injury.