WORKERS COMPENSATION COMMISSION

STATEMENT OF REASONS FOR DECISION OF THE APPEAL PANEL IN RELATION TO A MEDICAL DISPUTE

Matter Number:	**M1-6712/18**
Appellant:	**Matthew Outram**
Respondent:	**Insurance Australia Group (IAG) t/as CGU Workers Compensation**
Date of Decision:	**10 June 2020**
Citation:	**[2020] NSWWCCMA 101**

Appeal Panel:	
Arbitrator:	**Carolyn Rimmer**
Approved Medical Specialist:	**Dr Patrick Morris**
Approved Medical Specialist:	**Dr Julian Parmegiani**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 20 March 2020, Matthew Outram (Mr Outram) made an application to appeal against a medical assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission). The medical assessment was made by Dr Christopher Bench, Approved Medical Specialist (the AMS) and issued on 21 February 2020.

2. The respondent to the appeal is Insurance Australia Group (IAG) t/as CGU Workers Compensation (the respondent).

3. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - the assessment was made on the basis of incorrect criteria,
    - the MAC contains a demonstrable error.

4. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground(s) of appeal on which the appeal is made.

5. The Workers compensation medical dispute assessment guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the Workers compensation medical dispute assessment guidelines.

6. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* ed 1 April 2016 (the Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

7. The Appeal was made within 28 days of the date of the medical assessment.

RELEVANT FACTUAL BACKGROUND

8. Mr Outram developed a primary psychiatric injury in the course of his employment with the respondent as a senior case manager and technical advisor. The injury was deemed to have occurred on 17 August 2017.
9. Arbitrator John Harris in a Certificate of Determination (COD) dated 12 December 2019 found that Mr Outram sustained a psychological injury pursuant to s 4 of the *Workers Compensation Act* 1987 (the 1987 Act) deemed to have occurred on 17 August 2017. Arbitrator Harris found that the respondent's defence pursuant to s 11A of the 1987 Act failed.

10. The matter was referred to the AMS, Dr Bench, on 2 January 2020 for assessment of whole person impairment (WPI) of Mr Outram's psychological/psychiatric disorder attributable to the injury deemed to have occurred on 17 August 2017.

11. The AMS examined Mr Outram on 13 February 2020 and assessed 17% WPI in respect of the psychological/psychiatric disorder as a result of the injury. The AMS then made a deduction of 3% WPI pursuant to s 323 of the 1998 Act for a pre-existing condition. This resulted in a total assessment of 14% WPI as a result of the injury deemed to have occurred on 17 August 2017.

PRELIMINARY REVIEW

12. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Workers Compensation Medical Dispute Assessment Guidelines.

13. Neither party sought an opportunity to make oral submissions to the Appeal Panel. The Appeal Panel does not consider it would benefit by hearing oral submissions from the parties. The Appeal Panel shall therefore determine the Appeal without an Assessment Hearing.

14. Mr Outram did not request that he be re-examined by an Approved Medical Specialist, who is a member of the Appeal Panel.

15. As a result of that preliminary review, the Appeal Panel determined that it was unnecessary for Mr Outram to undergo a further medical examination because there was sufficient evidence on which to make a determination.

EVIDENCE

Documentary evidence

16. The Appeal Panel has before it all the documents that were sent to the AMS for the original medical assessment and has taken them into account in making this determination.

Medical Assessment Certificate

17. The parts of the medical certificate given by the AMS that are relevant to the appeal are set out, where relevant, in the body of this decision.

SUBMISSIONS

18. Both parties made written submissions. They are not repeated in full but have been considered by the Appeal Panel.

19. The appellant's submissions include the following:

- The AMS erred and/or applied incorrect criteria in assessing the appropriate deduction, if any, pursuant to s 323 of the 1998 Act. The AMS found a 17% WPI but deducted 3% WPI from that figure pursuant to s 323 to bring the total WPI to 14%.

- It was an error to find any deduction on the evidence, or in the alternative, the deduction should have been the amount dictated by s 323((2), namely 10% of the impairment (which would have been 1.7%).

- The AMS failed to give due regard to the remission of the pre-existing psychiatric condition.

- The AMS misapplied the concept of an adjustment for effect of treatment.

- Pursuant to s 323(2) if the extent of the deduction will be difficult or costly to determine, there is an assumption that the deduction is 10% of the impairment unless this assumption is at odds with the evidence.

- The assumption of 10% was not "at odds with the available evidence" and this was apparent on the face of the MAC.

- The analysis of the AMS at 10a of the MAC was flawed and erroneous. The AMS failed to explain why evidence that Mr Outram had previous episodic need for anti-depressant medication warranted the conclusion that he suffered in the past the same serious diagnosis that is now applicable, namely, "Major Depressive Disorder". The AMS failed to explain how the diagnostic criteria for that definition were applicable to his past condition or reported problems.

- The AMS accepted that the depressive illness was in remission at the time of the work injury and that treatment had "…provoked a total elimination of his impairments".

- None of the other medical opinions before the AMS opined that a deduction for pre-existing psychiatric illness be made, let alone one of 3% WPI.

- The only available conclusion when properly applying s 323(2) and the Guidelines was either a nil deduction, or at most a deduction of 10% of the impairment.

- If the AMS intended to depart from the s 323(2) assumption, then Clause 11.10 of the Guidelines provides that the AMS should measure the proportion of WPI due to a pre-existing condition and calculate pre-existing impairment using the same method for calculating current impairment level. This would involve applying the PIRS criteria and this was not attempted by the AMS. It is apparent that the AMS did not apply the relevant criteria at Chapter 11.10.

- In *Broadspectrum v Wills* [2019] NSWSC 1797 (*Wills*), where Meagher J noted at [12] to [15] that the plaintiff was largely but not completely asymptomatic and was under treatment at the time of her work injury, including medication and psychiatric counselling treatment. His Honour went on to note at [19], in order to make any deduction pursuant to s 323,

it is possible to do so in some circumstances even when the pre-existing condition is asymptomatic however only if the loss [permanent impairment] is to some extent due to the pre-existing condition. Here the AMS specifically found the pre-existing condition to be in remission and that treatment had led to the "total elimination of permanent impairment" of any pre-existing condition.

- In respect of the concept of an adjustment for the effect of treatment, the AMS erroneously confused the two distinct concepts of the assessment process set out at Paragraph 11.8 of the Guidelines and Clause 1.32 of the Guidelines.

- The "Effects of Treatment" adjustment contemplated by Clause11.8 and Clause-1.32 of the Guidelines clearly contemplates an increase of between 1% and 3% when treatment (such as effective medication) mitigates the effects of the injury being assessed. In this case the AMS used the framework of Clause 1.32 to decrease the WPI, relating it to the deduction for pre-existing condition on the basis that Mr Outram was in remission and that treatment had led to the "total elimination of permanent impairment" of any pre-existing condition.

- This is a misapplication of the statutory criteria and/or Guidelines and is a demonstrable error.

- The elimination of any pre-existing impairment by treatment does not in any way assist in quantifying the pre-existing impairment that may or may not exist. In short, the "Effects of Treatment" is an inappropriate method of assessing a deduction under s 323.

- The AMS wrongly concluded at 11c (i) of the MAC that the deductible proportion was 3%.

20. The respondent's submissions include the following:

- On the issue of the pre-existing psychological condition, the AMS noted on page 2 of the MAC that the onset of Mr Outram's difficulties was after the commencement of Ms Brennan as the branch manager at the end of 2016. The COD of Arbitrator Harris dated 12 December 2019 further noted the following [at 19]:

> "The applicant provided a statement dated 8 August 2018 where he addressed the matters he considered led to injury. Some of these incidents were, to adopt the words of his counsel, 'fairly general', such as the allegation that he was subject to being 'systemically bullied' by the acting branch manager from 28 December 2016 to 22 August 2017."

- The allegations of bullying were from 28 December 2016. There were various references in the clinical records of Charlestown Medical and Dental Centre in 2010, 2011, 2012, 2013, and 2016. Theses clinical records confirmed that Mr Outran had been prescribed both Cymbalta and Fluoxetine before the subject injury.

- The AMS took a detailed history at pages 3-5 of the MAC and, on questioning, Mr Outram conceded he had anxiety issues in 2010. On page 7 of the MAC, the AMS formed the view that "it is evident the applicant has a background history of depression and anxiety dating back to 2009" and that "he was on and off antidepressants from 2009 to the time of the clinical evaluation." This was supported by the clinical records referred to above.

- On page 7 of the MAC, the AMS noted that there had been "an abatement of his depression and anxiety in the lead up to the work injury provoked by evidence-based treatment with the antidepressant Cymbalta" and that there had been "an exacerbation of his Persistent Depressive Disorder" with the work injury causing "a further major depressive episode."

- At page 9 of the MAC, the AMS also expressed the view that, in his opinion, Mr Outram's "Major Depressive Disorder with anxious distress, recurrent was aggravated by the work injury" and otherwise maintained that "there is clear documented evidence the applicant suffered a depressive illness with anxiety pre-dating the work injury", which he considered to be consistent with a Major Depressive Disorder with anxious distress, recurrent. In this regard, the AMS records that Mr Outram advised that he had:

  > "…failed to be able to come off the antidepressant medication on a repeated basis such that he was on and off antidepressants for the seven to eight years preceding the work injury. He was being treated with Cymbalta at the time of the work injury. He asserted that his depression and anxiety was in remission, provoked by the Cymbalta. There was no evidence in the collateral materials presented for review to contradict such."

- A deduction of 3% WPI was not at odds with the evidence and therefore was not a demonstrable error. The AMS' findings were an expression of clinical judgment where the alternative conclusion (that no deduction or only a one-tenth deduction be applied) was not presented by the evidence and was not shown to be necessarily available.

- A mere difference of opinion between the AMS and the other medical practitioners on the issue of the s 323 deduction is insufficient to establish the application of incorrect criteria or the presence of a demonstrable error (*Parker v Select Civil Pty Ltd* [2018] NSWSC 140).

- The AMS expressed the view that although the extent of the deduction was difficult or costly to determine, on the available evidence, the deductible proportion was large and a one-tenth deduction was at odds with the available evidence. It was open to the AMS to express this view and, on this basis, he considered it appropriate to apply a 3% WPI deduction by utilising the adjustment for the effects of treatment on the pre-existing condition as a basis.

- The conclusions of the AMS are not inconsistent with the Guidelines and do not establish a demonstrable error or application of incorrect criteria.

- The AMS justified the 3% WPI deduction under s 323 of the 1998 Act by reference to the effects of treatment outlined in Clauses 1.32 and 11.8 of the Guidelines. In this regard, Clause 1.32 of the Guidelines provides that an assessor may increase the percentage WPI by 1%, 2% or 3% where effective long-term treatment results in apparent substantial or total elimination, but where the worker is likely to revert to the original impairment if treatment is withdrawn.

- Clause 11.8 provides that the pre-existing impairment is to be calculated using the same method for calculating the current impairment level. However, Clause 1.6 of the Guidelines also provides that assessors are to exercise their clinical judgment when making deductions for pre-existing injuries/conditions and Clause 1.27 provides that an assessor needs to take account of all available evidence.

- The AMS having established that Mr Outram suffered a pre-existing psychological condition and having formed the view that the condition was in remission due to antidepressant medication, appropriately applied the effects of treatment under Clauses 1.32 and 11.8 to the pre-existing psychological condition.

- Dr Thomas Oldtree Clark, in his report dated 4 July 2018, applied a 1% WPI for the effects of treatment to the current impairment level. It was therefore open to the AMS to apply the effects of treatment to the pre-existing impairment in accordance with Clause 11.10 of the Guidelines. On this basis, the AMS had applied the correct criteria and that there was no demonstrable error. It was appropriate for the AMS to utilise the 3% adjustment for the effects of treatment when determining the level of impairment for the pre-existing condition and deducting that assessment from the current impairment in accordance with s 323 of the 1998 Act.

- There was no requirement to apply Clause 11.10 of the Guidelines. In *Wills*, Meagher J noted [at 19] that the MAP declined to apply the clause on the basis that to do so "would produce an anomalous assessment contrary to the [relevant] principles" adopted in *Vitaz v Westform* (NSW) Pty Ltd [2011] NSWCA 254. Meagher J noted [at 20] that the MAP considered the deduction should be made on the following basis:

  > "Accordingly, the Panel is of the view that a deduction of 20% should be made. This reflects the severity and chronicity of her relapsing and remitting pre-existing conditions, the documented recurrent periods of impairment prior to the injury, but also acknowledges that Ms Wills had been asymptomatic and unimpaired at the time of the subject injury."

- The AMS in this matter adopted the reasoning applied by the Appeal Panel in *Wills* but did so by reference to the effects of treatment.

- In *Wills*, the MAP assessed the proportion of the plaintiff's current impairment due to her pre-existing conditions at 20% or 1/5th with Meagher J noting [at 15] that the MAP held there to be "no evidence that Ms Wills was clinically symptomatic at the time she suffered the subject injury." It was further noted [at 17] that the MAP considered that the pre-existing condition "does not have to be symptomatic and may contribute to the level of impairment caused by the subject injury even if it were asymptomatic." Accordingly, whether the pre-existing condition was asymptomatic or not completely asymptomatic is not determinative of whether there should be a deduction under s 323 of the 1998 Act.

- In this matter Mr Outram was clearly noted to be in receipt of treatment at the time of the injury. He was prescribed anti-depressant medication (Cymbalta) in December 2016 which was immediately before Mr Outram's complaints commenced on or about 28 December 2016. The decision in *Wills* is relevant and should be followed.

- The MAC should be confirmed.

FINDINGS AND REASONS

21. The procedures on appeal are contained in s 328 of the 1998 Act. The appeal is to be by way of review of the original medical assessment but the review is limited to the grounds of appeal on which the appeal is made.

22. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 the Court of Appeal held that the Appeal Panel is obliged to give reasons. Where there are disputes of fact it may be necessary to refer to evidence or other material on which findings are based, but the extent to which this is necessary will vary from case to case. Where more than one conclusion is open, it will be necessary to explain why one conclusion is preferred. On the other hand, the reasons need not be extensive or provide a detailed explanation of the criteria applied by the medical professionals in reaching a professional judgement.

23. Though the power of review is far ranging it is nonetheless confined to the matters that can be the subject of appeal. Section 327(2) of the 1998 Act restricts those matters to the matters about which the AMS certificate is binding. Section 327(2) was amended with the effect that while the appeal was to be by way of review, all appeals as at 1 February 2011 were limited to the ground(s) upon which the appeal was made. In *New South Wales Police Force v Registrar of the Workers Compensation Commission of New South Wales* [2013] SC 1792 Davies J considered that the form of the words used in s 328(2) of the 1998 Act being, 'the grounds of appeal on which the appeal is made' was intended to mean that the appeal is confined to those particular demonstrable errors identified by a party in its submissions.

24. In this matter the Registrar has determined that he is satisfied that at least one of the grounds of appeal under s 327(3)(d) was made out, in relation to the AMS' consideration of s 323 of the 1998 Act.

Discussion

25. The Panel reviewed the history recorded by the AMS, his findings on examination, and the reasons for his conclusions as well as the evidence in this matter.

26. On page 4 of the MAC under "Details of any previous or subsequent accidents, injuries or condition", the AMS wrote:

> "The applicant noted his first mental health contact was in 2009 following a very hostile separation from his then-wife. He reported having had difficulties with depression, feeling sad, tearful 'I didn't feel like doing anything, I miss my daughter'. He had no time off work. He denied having had any suicidal ideation. He consulted with his then general practitioner Dr Peter Ashley. He was unsure of any diagnosis made. He was commenced on the antidepressant Lexapro, which he took for approximately twelve months. He was referred to a psychologist Linda Johansson. He was unsure of the diagnosis of Ms Johansson. He saw her for six to nine months. Although initially denying have had any other psychiatric medication, he was questioned with regard to the collateral materials. He acknowledged having subsequently been treated with the antidepressant Cymbalta 'that's what I'm still on'.
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> He was unable to tolerate sertraline. He could not recall having been treated with fluoxetine.
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> He noted having been on and off medication from 2009 until the time of the work injury noting 'it hurt my head to come off it … I had trouble coming off it'.

He was also questioned with regard to the background history of anxiety. He asserted he had never previously suffered anxiety prior to the work injury. He was questioned with regard to the notations dating back to 2010. He noted 'that would have been because of GIO'. He reported having been subjected to harassment in the workplace. He felt like not attending work. He felt sick in the stomach and had insomnia secondary to his ruminations. He never filed a workers compensation claim. He noted having resigned from his position. He stated, 'they made my life a living hell for the last year and a bit'.

On review, he denied any other episodes of depression. He denied any past history of psychiatric admissions. He denied any history consistent with past episodes of Posttraumatic Stress Disorder, Panic Disorder, Obsessive Compulsive Disorder, or Social Anxiety Disorder. He denied any history of deliberate self-harm or suicide attempts."

27. On page 6 of the MAC, under "Summary of injuries and diagnoses" the AMS wrote:

> "It is the evaluator's opinion the applicants meets diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition for Persistent Depressive Disorder with anxious distress and Alcohol Use Disorder.
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> With regard to the Persistent Depressive Disorder with anxious distress, it is evident the applicant has a background history of depression and anxiety dating back to 2009. It is noted he was on and off antidepressants from 2009 to the time of the clinical evaluation.
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> Nonetheless, it would appear there had been an abatement of his depression and anxiety in the lead up to the work injury provoked by evidence-based treatment with the anti-depressant Cymbalta. Following the work injury, he has had an exacerbation of his Persistent Depressive Disorder with increased depressed, anxious and irritable mood, lethargy, lack of libido, inability to enjoy activities, being more isolative and withdrawn, passive suicidal ideation and engaging in reckless behaviours with little regard for his health. In this context, It is the evaluator's opinion the work injury had caused a further major depressive episode. In this context, he meets diagnostic criteria for a Persistent Depressive Disorder with intermittent major depressive episodes, current major depressive episode.
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> The applicant meets diagnostic criteria for an Alcohol Use Disorder. He continues to drink in a pattern known to be injurious to one's mental and physical health, including drinking on a daily basis. Moreover, he continues to binge drink once or twice per week including to the point of having alcoholic blackouts, clearly indicative of the negative impact upon his physical health. He has been unable to cease alcohol use. In this context he meets diagnostic criteria for an Alcohol Use Disorder. I accept that he was not using alcohol in the hazardous fashion prior to the work injury and as such the Alcohol Use Disorder was also caused by the work injury."

28. The AMS on page 9 of the MAC under "My opinion and assessment of whole person impairment" wrote:

> "As noted above, there would appear to be contemporaneous collateral materials to confirm the applicant had suffered a further major depressive episode provoked by the work injury. In this context, it is the evaluator's opinion his Major Depressive Disorder with anxious distress, recurrent was aggravated by the work injury. Given the applicant's depression has lasted for over two years without improvement, he now meets diagnostic criteria for Persistent Depressive Disorder with anxious distress with intermittent major depressive episodes. It is the evaluator's opinion, the work injury has resulted in impairments.

…

As noted above, there is clear documented evidence the applicant suffered a depressive illness with anxiety pre-dating the work injury. Such is most consistent with a Major Depressive Disorder with anxious distress, recurrent. The applicant noted having failed to be able to come off the antidepressant medication on a repeated basis such that he was on and off antidepressants for the seven to eight years preceding the work injury. He was being treated with Cymbalta at the time of the work injury. He asserted that his depression and anxiety was in remission, provoked by the Cymbalta. There was no evidence in the collateral materials presented for review to contradict such. In this context, I accept that his depressive illness was in remission at the time of the work injury as a result of evidence-based psychiatric treatment. In this context, he attracts a 3% whole person impairment for the pre-existing condition given that his treatment had provoked a total elimination of his impairments."

29. On page 13 of the MAC, the AMS expressed the opinion that Mr Outram had suffered from a relevant previous injury or pre-existing condition, namely, Major Depressive Disorder with anxious distress recurrent. The AMS wrote:

"b. The previous injury, pre-existing condition or abnormality directly contributes to the following matters that were taken into account when assessing the whole person impairment that results from the injury, being the matters taken into account in 10a, and in the following ways:

(i) The applicant noted after ceasing antidepressant medications on numerous occasions between 2009 to late 2016, he had recurrent episodes of anxiety and depression. This was similarly reflected in the collateral materials presented for review.

c. Whilst the extent of the deduction is difficult or costly to determine the available evidence is that the deductible proportion is large and a deduction of one tenth is at odds with the available evidence. In my opinion, the deductible proportion is 3% for the following reasons:

(i) It is evident the applicant had multiple previous episodes of anxiety and depression, which were successfully treated with evidence-based antidepressant medication. I accept at the time of the work injury, his Major Depressive Disorder was in remission as a result of the evidence-based psychiatric treatment. In this context, he would attract a 3% adjustment for the effects of treatment for the total elimination of permanent impairment provoked by the treatment."

30. The Appeal Panel noted that the clinical records from Charlestown Medical and Dental Centre confirmed Mr Outram had been prescribed duloxetine in April 2016 and in December 2016. The Appeal Panel noted the following entries:

(a) On 19 October 2009, Dr Peter Ashley noted "wc see cert - Medicare has depression and will see for Mental Health GP plan to start Lexapro 10mg".

(b) On 6 April 2010, Dr Peter Ashley noted "no longer requires Lexapro."

(c) On 1 June 2010, Dr Peter Ashley noted "works at GIO feels boss is harassing him, she talks down to him and has issued a notice a meeting for his dismissal. Advise duties where he is not in contact with her". Type of injury was recorded as "harassment" and an Initial WorkCover certificate was provided.

(d) On 15 July 2010, Dr Collins Oku-Oleng noted “has run out of Lexapro and requested further script”.

(e) On 28 November 2010, Dr Helen Willoughby noted:

> “sees counsellor through DOCS; Linda Johansson - 12/12: but she unwell. Depressed; suicidal thoughts occasionally…. weight increased and fatigue Lexapro 10mg. Can either increase dose or change to Pristiq … counselling; agrees to be safe until R/V 1/52. New job; not keen to take time off. Dx: anxiety with depression after break up and work conflict.”

(f) On 29 November 2010, Dr Helen Willoughby noted referral under a GP Mental Healthcare Plan

(g) On 6 December 2010, Dr Helen Willoughby noted “in Court today re custody of 2 YO Vienna; not been successful. V upset. Off Lexapro; to start Pristiq tomorrow. Counselling. Safe R/V 1/52. Great time with/other 2 kids as well as w Vienna”.

(h) On 1 March 2011, Dr Helen Willoughby noted “Needs new W/C as on full duties, but still doing gym, physio & takes analgesia. Not happy on Lexapro; in cwt & fatigue…after 2/7 resume Pristiq…happier. Counsellor EAP.”

(i) On 14 March 2011, Dr Helen Willoughby noted stresses with “Lisa and Sarah ++; re custody issues…counselling; has good support from family. Wanting to resume Duromine … low dose”.

(j) On 9 May 2011, Dr S Ardavan Hamidi noted “Here as looking for his medication, discussed seems not all 100% well with 10mg, discussed and increased to 20mg side effects discussed in length”.

(k) On 5 December 2011, Dr Sayed Hasan noted a request for repeats of Mobic and Pristiq and “Would like to increase Pristiq dose to 100mg from 50mg”.

(l) On 2 March 2012, Dr David Jones noted “Pristiq made him angry, Lexapro made him hungry. Try Fluoxetine. Also needs repeat of Mobic for his arthritis.”

(m) On 29 September 2012, Dr Helen Willoughby noted “looking to lose weight…not depressed”.

(n) On 2 February 2013, Dr Helen Willoughby noted “looking for losing more weight… not on SSRI, SNRI at the moment.”

(o) On 1 November 2014, Dr Helen Willoughby noted “looking for a review of R knee… no more depression there.”

(p) On 5 August 2015, Dr Sarah Philipson noted “for Prozac and Voltaren stable on both – 5 days without at the moment – getting headaches, keen on staying on, maintains his mood/ irritability”. He was continued on Fluoxetine (Prozac)

(q) On 8 April 2016, Dr Clifford Ganga prescribed Duloxetine (also known as Cymbalta).

(r) On 11 December 2016, Dr Mark Adamski noted “needs Cymbalta, feels well on low dose”. He was prescribed Cymbalta 30mg daily.

31. Dr Vickery recorded a prior psychological history of relating to a stressful de-facto relationship break-up in 2009 with court proceedings in relation to access issues with the youngest daughter. The applicant was then treated with antidepressant medication and remained on a low dose.

32. Dr Thomas Oldtree Clark noted in his report dated 4 July 2018, that Mr Outram had been subjected to bullying and harassment in the workplace. He noted that Mr Outram was drinking on a daily basis, had "slackened off" with regard to looking after his home and self-care, and he had a partner for the last four years but their relationship was fragile. Dr Oldtree Clark diagnosed Major Depressive Disorder as the result of the work injury. In a separate impairment assessment dated 4 July 2018, Dr Oldtree Clark completed an assessment of WPI of 17 % with a 1% adjustment added for the effects of treatment.

33. Helen Kelson, in a Client Intake Form dated 11 September 2017, noted Mr Outram was being treated with Cymbalta 90 mg daily. She reported that he had presented with work-related incidents with the manager Bernie. She noted he previously suffered depression after a relationship breakdown and custody access issues being treated with antidepressants since that time. She noted "depression was in remission".

34. Garling J in *Pereira v Siemens Ltd* [2015] NSWSC 1133 summarised at [81]-[90] the steps to be taken by a decision maker in respect of s 323 of the 1998 Act as follows:

> "81. The assessment required by s 323 is one which must be based on fact, not assumptions or hypotheses: *Elcheikh v Diamond Formwork* (NSW) Pty Ltd (In Liq) [2013] NSWSC 365 at [89]; *Matthew Hall Pty Ltd v Smart* [2000] NSWCA 284 at [33]; *Ryder v Sundance Bakehouse* [2015] NSWSC 526 at [40] (*Ryder*).
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> 82. The process encompassed by s 323 requires the application of each of the following steps before reaching the ultimate conclusion of the existence of a pre-existing injury which has an impact on the assessment of the injury the subject of the worker's claim.
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> 83. first step requires a finding of fact that the worker has suffered an injury at work which has resulted in a degree of permanent impairment which has been assessed pursuant to s 322 of the 1998 Act: see *Elcheikh* at [125].
>
> 84. The second step which needs to be addressed is, assuming such an injury has been sustained and impairment has resulted, what is the extent of that impairment expressed as a percentage of the whole person: see *Cole v Wenaline Pty Ltd* [2010] NSWSC 78 at [38] (*Cole*); *Elcheikh* at [126].
>
> 85. The third matter to be addressed is whether the worker had any previous injury, or any pre-existing condition or abnormality. The previous injury does not have to be one in respect of which compensation is payable under the 1998 Act. If the phrase 'pre-existing condition or abnormality' is to be relied upon, then such condition or abnormality must be a diagnosable or established clinical entity: *Fire & Rescue NSW v Clinen* [2013] NSWSC 629.
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> 86. A finding of the existence of a previous injury can be made without the presence of symptoms, but there must be evidence which demonstrates the existence of that pre-existing condition: *Mathew Hall* at [31]-[32].
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> 87. The pre-existing injury or condition must, on the available evidence, have caused or contributed to the assessed whole person impairment: see *Matthew Hall* at [32]; *Cole* at [29]-[31]; *Elcheikh* at [88] and *Ryder* at [42].

88. It cannot be assumed that the mere existence of a pre-existing injury means that it has contributed to the current whole person impairment: *Clinen* at [32]; *Cole* at [30]; *Elcheikh* at [91]. What must occur is that there must be an enquiry into whether there are other causes of the whole person impairment which reflect a difference in the degree of impairment: *Ryder* at [45].

89. Next in dealing with the application of s 323, the extent of the contribution, if any, of the pre-existing condition to the current impairment must be assessed in order to fix the deductible proportion. If the extent of the deductible proportion will be difficult or costly to determine, an assumption is made that the deductible proportion will be fixed at 10%, unless that is at odds with the available evidence: s 323(2) of the 1998 Act.

90. Each of these steps, and considerations, is a necessary element of a determination that an assessed whole person impairment is to be reduced by a deductible proportion by virtue of the application of s 323 of the 1998 Act."

35. Schmidt J said in *Cole* at [30] that:

> "[T]he assessment must have regard to the evidence as to the actual consequences of the earlier injury, pre-existing condition or abnormality."

36. In *Ryder* at [45] and [54] Campbell J observed that:

> "[45] What s 323 requires is an inquiry into whether there are other causes, (previous injury, or pre-existing abnormality), of an impairment caused by a work injury. A proportion of the impairment would be due to the pre-existing abnormality (even if that proportion cannot be precisely identified without difficulty or expense) only if it can be said that the pre-existing abnormality made a difference to the outcome in terms of the degree of impairment resulting from the work injury. If there is no difference in outcome, that is to say, if the degree of impairment is not greater than it would otherwise have been as a result of the injury, it is impossible to say that a proportion of it is due to the pre-existing abnormality. To put it another way, the Panel must be satisfied that but for the pre-existing abnormality, the degree of impairment resulting from the work injury would not have been as great."

37. Clause 1.32 of the Guidelines provides:

> "1.32 Where the effective long-term treatment of an illness or injury results in apparent substantial or total elimination of the claimant's permanent impairment, but the claimant is likely to revert to the original degree of impairment if treatment is withdrawn, the assessor may increase the percentage of WPI by 1%, 2% or 3%. This percentage should be combined with any other impairment percentage, using the Combined Values Chart. This paragraph does not apply to the use of analgesics or anti-inflammatory medication for pain relief."

38. Clause 11.8 of the Guidelines states:

> "Effects of Treatment
>
> 11.8 Consider the effects of medication, treatment and rehabilitation to date. Is the condition stable? Is treatment likely to change? Are symptoms likely to improve? If the injured worker declines treatment, this should not affect the estimate of permanent impairment. The psychiatrist may make a comment in the report about the likely effect of treatment or the reasons for refusal of treatment."

39. Clause 11.10 of the Guidelines states:

> "Pre-existing impairment
>
> 11.10 To measure the impairment caused by a work-related injury or incident, the psychiatrist must measure the proportion of WPI due to a pre-existing condition. Pre-existing impairment is calculated using the same method for calculating current impairment level. The assessing psychiatrist uses all available information to rate the injured worker's pre-injury level of functioning in each of the areas of function. The percentage impairment is calculated using the aggregate score and median class score using the conversion table below. The injured worker's current level of WPI% is then assessed, and the pre-existing WPI% is subtracted from their current level, to obtain the percentage of permanent impairment directly attributable to the work-related injury. If the percentage of pre-existing impairment cannot be assessed, the deduction is 1/10th of the assessed WPI."

40. As noted above, the appellant submitted that the AMS erred and/or applied incorrect criteria in assessing the appropriate deduction, if any, pursuant to s 323 of the 1998 Act.

41. The Appeal Panel was satisfied that the AMS did not adopt the methodology set out in Clause11-1 of the Guidelines. The AMS did not refer to or assess the level of functioning in the various Psychiatric impairment rating scales (PIRS) categories pre-injury or consider whether the pre-existing injury or condition, on the available evidence, caused or contributed to the assessed WPI. He did not properly explain why he did not assess and rate the pre-injury level of functioning in each of the PIRS categories or specifically state that the percentage of pre-existing impairment could not be assessed. While the AMS did say that the extent of the deduction was difficult or costly to determine, he gave no reasons for this conclusion. It was not clear if the AMS considered that there was no impairment that would be rated in the PIRS categories caused by the pre-existing condition at the time when the subject injury occurred or whether he was unable to rate the pre-injury level of functioning in each of the PIRS categories. The Appeal Panel considered it was possible that Mr Outram could have been in remission but still have a level of impairment.

42. The AMS, without adequate explanation, proceeded to adopt an impairment assessment for the pre-existing condition based on the effects of treatment as a means of assessing contribution of pre-existing impairment. The Appeal Panel considered that the failure to adopt the methodology in Clause 11.1 or to clearly explain why that methodology was not adopted was an error and the assessment was made on the basis of incorrect criteria.

43. As noted above, the Appeal Panel noted that the AMS considered that the extent of the deduction was difficult or costly to determine but then expressed the view that the available evidence was that the deductible proportion was large and a deduction of one tenth was at odds with the available evidence.

44. The Appeal Panel considered that the evidence did not support the finding that the deductible proportion was large. It was clear that Mr Outram was on medication before the subject injury and the evidence suggested that his pre-existing condition was well controlled by such medication. The Appeal Panel considered that where Mr Outram was well controlled by medication prior to the subject injury, it would be difficult to work out the precise contribution of the pre-existing injury to the impairment assessed. However, the Appeal Panel did not agree that an assessment of 3% WPI, which was the maximum allowed for the effects of treatment, was an appropriate figure for a s 323 deduction in this case.

45. The respondent referred to the decision of *Wills*. The Appeal Panel accepts that there is no requirement to apply Clause 11.10 of the Guidelines if by applying the Clause it "would produce an anomalous assessment contrary to the [relevant] principles". The Appeal Panel noted that in *Wills* the worker was found to have a pre-existing impairment, notwithstanding treatment, causing recurrent periods of psychosocial and vocational impairment. Further, in *Wills* the worker was under treatment at the time of her work injury, including medication and psychiatric counselling treatment. The facts in this case are quite different and Mr Outram was working in 2009 and 2010 when he first reported symptoms and there was no evidence that he had any time off work in respect of a pre-existing psychological condition or was having psychiatric counselling treatment at the time of the subject work injury.

46. The AMS justified the 3% WPI deduction under s 323 of the 1998 Act by reference to the effects of treatment outlined in Clauses 1.32 and 11.8 of the Guidelines. In this regard, Clause 1.32 of the Guidelines provides that an assessor may increase the percentage WPI by 1%, 2% or 3% where effective long-term treatment results in apparent substantial or total elimination, but where the worker is likely to revert to the original impairment if treatment is withdrawn. It is possible that in making an assessment of impairment from a pre-existing condition, an assessor may increase the percentage WPI by 1% 2% or 3%, however, the AMS did not actually make an assessment of WPI for the pre-existing injury and then add an additional percentage for the effects of treatment.

47. The Appeal Panel after reviewing the clinical notes from Charlestown Medical and Dental Centre, which cover the period from 2009 to July 2018, considered that a deduction of 10% under s 323 of the 1998 Act and Clause 11.1 of the Guidelines was not at odds with the evidence. The Appeal Panel considered that there was a serious decline in Mr Outram's mental state and a range of symptoms developed including increased depressed, anxious and irritable mood, lethargy, lack of libido, inability to enjoy activities, being more isolative and withdrawn, passive suicidal ideation and engaging in reckless behaviours with little regard for his health and such symptoms were attributable to the work injury.

48. In conclusion, the Appeal Panel considered that there has been an incorrect application of relevant assessment criteria, that is, the Guidelines and a demonstrable error in the AMS' assessment. The Appeal Panel makes a deduction of one-tenth pursuant to s 323 of the 1998 Act and Clause 11.10 of the Guidelines. Therefore, a deduction of 1.7% (which is rounded up to 2% WPI) is applied to the assessment of 17% WPI. This results in a total assessment of 15% WPI as a result of the injury deemed to have occurred on 17 August 2017.

49. For these reasons, the Appeal Panel has determined that the MAC issued on 21 February 2020 should be revoked. and a new MAC should be issued. The new certificate is attached to this statement of reasons.

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **6712/18**
Applicant: **Matthew Outram**
Respondent: **Insurance Australia Group (IAG) t/as CGU Workers Compensation**

This Certificate is issued pursuant to s 328(5) of the *Workplace Injury Management and Workers Compensation Act* 1998.

The Appeal Panel revokes the Medical Assessment Certificate of Dr Anderson and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

Table - Whole Person Impairment (WPI)

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in the Guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA 5 Guides**	**% WPI**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Sub-total/s % WPI (after any deductions in column 6)**
1.Psychiatric and Psychological disorders	(deemed) 07/08/17	Chap 11 – pages 54-60 paragraphs 11.1 to 11.20	n/a	17%	1/10th	15%
Total % WPI (the Combined Table values of all sub-totals)					**15%**	

Carolyn Rimmer
Arbitrator

Dr Patrick Morris
Approved Medical Specialist

Dr Julian Parmegiani
Approved Medical Specialist

10 June 2020

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE MEDICAL ASSESSMENT CERTIFICATE OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION