WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-2979/20**
Appellant:	**Secretary, Department of Communities and Justice**
Respondent:	**Deborah Doulman**
Date of Decision:	**23 December 2020**
Citation No:	**[2020] NSWWCCMA 183**

Appeal Panel:	
Arbitrator:	**Ross Bell**
Approved Medical Specialist:	**Dr Patrick Morris**
Approved Medical Specialist:	**Dr Douglas Andrews**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 2 October 2020 Secretary, Department of Communities and Justice (appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Wayne Mason an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 7 September 2020.

2. 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.

3. 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.

4. The Workers compensation medical 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 assessment guidelines.

5. 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).

RELEVANT FACTUAL BACKGROUND

6. The AMS provides a useful summary of events including the history of the injury at Part 4,

> "…
> Ms Doulman described her work prior to 2017 as satisfactory. She was responsible for looking after the needs of children in out-of-home care, helping them transition to independent living when they were old enough, and in some cases transition back to the care of the parents from whom they were removed. This required regular visits to

the children throughout a wide area of South Western New South Wales. She identified their needs for equipment and developed plans for the purchase of these items such as computers, furniture, accommodation, etc. The plans were then approved by her senior officers and it was up to her to implement them.

She said difficulties arose when her previous manager finished work and a new manager Ms Lara Crawford commenced. This occurred around May or June 2017. She said many plans that had been approved in the past were rejected by Ms Crawford, which meant she had to go back to the children and explain they would not get the items they expected. She said many of the children became upset and abused her. She explained they were very damaged children and it had taken her a long time to develop their trust. She said the language they used towards her was often very crude and insulting but she understood why they felt the way they did. What distressed her was the fact that she was put in a position where she had to let them down. She said the longer this situation went on the more internal difficulty she was having. I asked why the plans were being rejected and she said she believed Ms Crawford wanted to be a shining light and save $2 million . She said it really upset her that the organisation was placing saving money ahead of the needs of the children they were tasked to support.

Ms Doulman said she was regularly clashing with Miss Crawford about this matter in addition to receiving very abusive phone calls from the children. She was frequently required to change the plans she had submitted and approval of these changes by Ms Crawford took much longer than had been the case in the past. She became anxious that she was letting the children down and they couldn't understand why things had changed.

I enquired about the nature of her relationship with the children and explored the possibility that she was unhealthily over-involved. I decided this was not the case. She said she did become an advocate for the children because they had no one else to fight for them but she did not love them dearly . She said she understood what had happened to them in the past and why they were yelling at her for letting them down yet again. Ms Doulman said when she tried to discuss this aspect of the problem with Ms Crawford she did not seem to understand. She said she often left such a discussion feeling like she wanted to go back to her desk and bash her head on it.

Ms Doulman said she was churning inside with distress and anxiety. She was unable to sleep. She would ruminate on the problems all the time and had difficulty getting to sleep. She felt she was in a lose-lose . She would wake up at 3 am worrying about it and take until 5 am to get back to sleep. She was having panic attacks during the night and would jerk awake in an agitated state with her heart racing. She said she felt terrified but did not know why. She couldn't remember if she had been having a nightmare. She said often there were images of Ms Crawford associated with these panic states. Her state of distress became so bad she was unable to remain at work and was off work from August until November 2017. She sought help from her GP and was referred to psychologist Ms Jenny Flannery who identified PTSD-like symptoms and focused her treatment on these.

Following this a graduated return to work plan was developed commencing with one day per week and gradually building up. Ms Doulman said she was placed under increasing pressure by Miss Crawford to resume her pre-injury duties. She was told she could not stay in the office if she did not get well. She said there were no suitable duties available for her. Ms Doulman believed this was not the case and was of the opinion there were many things she could do. She said at one point Ms Crawford asked her to accompany another caseworker on a home visit to a particular child and she refused. Ms Doulman had removed a child from this woman s care in the past and knew the woman hated her as a result. She said Ms Crawford was aware of this but

said if Ms Doulman couldn't do it she should not still be here. Ms Doulman said she became extremely anxious and had a panic attack and consulted her GP saying she couldn't do it. The general practitioner suggested that she work for three hours on two days per week but at a meeting in March 2018 she was told this type of work was not available. Again she stated she knew there were suitable duties available.

She said at this point she walked around for about a week as if she was not in her body. She was describing the intense anxiety experience of depersonalisation. She then said she fell into a black hole such that she struggled to get out of bed and on some days wasn't able to get out of bed at all. She struggled for months and said if she did get out of bed she would simply sit in a lounge chair. She said she stayed in her pyjamas for six months. During most of 2019 and into 2020 she did very little. She has totally withdrawn from friendship groups who were largely comprised of people from work. She said one friend calls in regularly to see her but she does not go out to visit anybody.

She initially consulted with EAP psychologist Ms Jenny Flannery. She saw her for about 12 months on a weekly basis during which time she did some EMDR work attempting to minimise the intrusive recurring images of Miss Crawford; she said this was only partially successful. When Miss Flannery took another job her care was transferred to psychologist Ms Angela Webb who visited from Parkes. She said it was difficult because she had to retell her story. She then saw her on a monthly basis through 2019. She said the sessions were due to recommence in February 2020 but this didn't happen because Ms Webb was available only one day per week. She said she has received another GP Mental Health Care Plan to commence with yet another psychologist.

Throughout the time of her difficulties at work she was taking the antidepressant desvenlafaxine 100mg which had been prescribed by her Canberra GP years earlier. She was referred to psychiatrist Dr Sanjay Sinha of Dubbo. She said she has had an initial A/V consultation and then was driven to her second appointment in Dubbo by her husband Mark. Dr Sinha increased her antidepressant dosage of desvenlafaxine from 100mg to 150mg. She said there was initially some response to this but this seems to have dissipated. She continues to consult regularly with her general practitioner in Young, Dr Natasha Adjani. She no longer travels to Canberra every six months to consult with Dr Nambiar."

PRELIMINARY REVIEW

7. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the WorkCover Medical Assessment Guidelines.

8. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because the grounds of appeal can be addressed without recourse to re-examination.

EVIDENCE

Documentary evidence

9. 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

10. 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

11. Both parties made written submissions. They are not repeated in full but have been considered by the Appeal Panel and are briefly summarised below.

Appellant

12. The appellant submits that the AMS has erred in applying s 323 of the 1998 Act, with incorrect diagnosis of the pre-existing condition and failure to properly apply a deduction to the impairment. An error was made in relying on s 323 (2) of the 1998 Act. The AMS also erred in not using s 324(1) of the 1998 Act to seek clarification from Dr Nambiar as to the pre-existing component.

13. The AMS also erred in relying on the history taken from the respondent worker which has resulted in incorrect PIRS ratings for Social Functioning and Employability.

14. The MAC should be revoked with assessments for Social Functioning and Employability to be assessed at Class 1 and Class 3, respectively. There should be a 50% deduction pursuant to s 323 of the 1998 Act.

Respondent

15. The respondent submits that there is no demonstrable error or use of incorrect criteria. The AMS states he took all the evidence into account in arriving at his conclusions. The AMS was entitled to make his own assessment of the pre-existing condition. The respondent was living a normal life before 8 August 2017 and was able to work and interact with her husband in a normal manner whereas afterwards she could not.

16. The diagnosis of the AMS for the pre-existing condition should be accepted. No other doctor gives a contrary diagnosis. The AMS considered Ms Burgess' report at page 10 of the MAC and was aware of the treatment given for the prior psychological condition.

17. The deduction of 1/10 under s 323(2) was available because the AMS found the pre-existing proportion costly or difficult to determine. The AMS had Ms Burgess' notes and the history of the respondent that she had been on medication from the time of the motor vehicle accident. The AMS did not need to contact Dr Nambiar in these circumstances.

18. The grounds in relation to Employability and Social Functioning rely on the assumption that the AMS should not have accepted the respondent's evidence on her inability to work. There is no evidence contrary to the statement as set out at paragraph 47 of the appellant's submissions. The assessment of Dr Oldtree Clark was nearly two years before the assessment by the AMS and circumstances had changed. The AMS did consider Ms Moodely's negative opinion of the respondent at page 10 of the MAC.

19. The MAC should be confirmed.

FINDINGS AND REASONS

20. 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.

21. 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.

Issue – Assessment for pre-existing condition under s 323 of the 1998 Act and paragraph 11.10 of the SIRA Guidelines

22. For a deduction to be properly made there must be evidence that there is a pre-existing injury, condition, or abnormality; and that this element contributes to the impairment[1]; and "assumption will not suffice".[2]

23. In *Ryder v Sundance Bakehouse* [2015] NSWSC 526, Campbell J explained the requirement (emphasis in original),

> "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."

24. The Panel notes that the approach to be taken with s 323 with psychological injury is set out at paragraph 11.10 of the SIRA Guidelines [emphasis added],

> "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.**"

25. The AMS reports previous medical issues at Part 4,

> "Ms Doulman said she developed tension headaches in her late teens and had managed them herself with over-the-counter medications until she was in her early-30s. She then developed trigeminal neuralgia in addition to the tension headaches and these were managed by her Canberra general practitioner, Dr Nambiar, who sub-specialised in the treatment of neuropsychiatric conditions. Treatment of these pain conditions and the associated secondary depression consisted of Lyrica, Mobic, Tenormin, Maxalt and various antidepressant agents over the years. During the last seven or eight years Ms Doulman also developed migraine and this has been treated with Topamax. She informed me that she had occasionally missed work because of pain but not because of depression and she had never been hospitalised for the treatment of depression.

[1] *Cole v Wenaline Pty Ltd* (2010) NSWSC 78 (*Cole*).
[2] *Fire & Rescue NSW v Clinen* [2013] NSWSC 629.

> In 2002, Ms Doulman was involved in a motor accident near her farming property. Her 11-year-old son was a passenger in the car when a rear tire blew out and she collided with a bank of earth beside the road. She developed depressive and PTSD-like symptoms for which she received psychological counselling over a few months. She said these symptoms resolved and she had no ongoing psychological problems."

26. The AMS was aware of ongoing medication for what the AMS describes as "low level" and "mild" depression over the years due to the pain conditions up to the time of the subject injury. He does not say that Ms Doulman recovered from her depression prior to the subject injury.

27. The Panel notes that whether the mild depressive condition was due to the 2002 motor accident or the pain disorders, or both, is not of any practical consequence. It was open to the AMS to form the opinion that the on-going low level depression related to the pain conditions and that there had been recovery from the effects of the motor accident. The appellant does not indicate how the opinion of the AMS on the cause of the pre-existing mild depression has led to a demonstrable error on the face of the Certificate.

28. That they were low level depressive symptoms is consistent with Ms Doulman's functioning in a demanding work role before the subject injury. The AMS was aware of the history recorded by Ms Burgess that Ms Doulman saw Dr Nambiar twice each year regarding the depressive condition.

29. The appellant seems to be conflating diagnosis and causation. The diagnosis is mild depression, and it had been easily managed with medication to the extent that symptoms were generally absent. Contrary to the submissions of the appellant the condition was not of much significance to Ms Doulman. She visited her general practitioner twice each year but was able to function at normal levels in her life including her challenging work as a teacher and case worker. As to the length of time Ms Doulman had been experiencing the mild depression it seems to the Panel that the appellant assumes a correlation between longevity severity, a correlation that does not exist.

30. The Panel notes that had the AMS been able to assess the pre-existing condition on the PIRS the outcome would likely have been zero impairment. The appellant's submission that the deduction for the pre-existing impairment should be at least 50% is baseless.

31. The submission that the AMS should have contacted Dr Nambiar pursuant to s 324 of the 1998 Act is rejected by the Panel. The AMS had ample evidence before him to arrive at his conclusions, and Dr Nambiar's opinion as to the origins of the ongoing mild symptoms would have been of no assistance. The AMS was able to form his own view about this.

32. The Panel notes that the symptoms and diagnosis that now pertain for Ms Doulman are at a level well above mild, as reflected in the AMS' summary,

> "I have diagnosed a major depressive disorder with anxious distress. She has depressed mood most of the day nearly every day and has diminished interest and pleasure in almost all of her previous activities. She suffers from insomnia and displays psychomotor retardation. She suffers from loss of energy and feels she has let down the children she was responsible for. She has a diminished ability to think and concentrate and she experiences recurrent thoughts of death. The panic attacks and the severe anxiety she experiences are secondary to her depressive disorder, as are the ruminations and the voices in her head."

33. The application of a 10% deduction under paragraph 11.10 of the SIRA Guidelines by the AMS was open in the circumstances of this matter, and the AMS explains this at Part 10.a.,

> "Ms Doulman struggled with a low-grade chronic depression over the years secondary to her pain conditions of tension headache, trigeminal neuralgia and migraine. In

addition to the use of specific agents for the treatment of these conditions her general practitioner also prescribed a variety of anti-depressant agents. There was never a requirement for hospitalisation regarding her depression. However in my opinion there was a pre-existing vulnerability to depression and for that reason I believe a 1/10 deduction is required."

34. The AMS says at Part 11 regarding the pre-existing condition,

> "There was an ongoing pre-existing low-level chronic predisposition to depression arising from her pain conditions. She received various psychiatric medications from her Canberra general practitioner in an attempt to moderate her pain experience and to treat the depression arising. This depressive condition did not reach a level requiring specific treatment, except for a brief period following a motor accident in 2002 when she required specific psychological treatment and made a good recovery."

35. There is no demonstrable error regarding the deduction for the pre-existing condition and the assessment in based on the correct criteria.

PIRS Categories of Social Functioning; and Employability

36. The importance of the exercise of clinical judgement by the AMS in the process of assessment was noted by the Supreme Court in *Glenn William Parker v Select Civil Pty Limited* [2018] NSWSC 140 (*Parker*),

> "In *Ferguson v State of New South Wales* [2017] NSWSC 887 at [23], Campbell J cited with approval *NSW Police Force v Daniel Wark* [2012] NSWWCCMA 36 ('*Wark*'), where it is stated at [33]:
>
> > '…the pre-eminence of the clinical observations cannot be understated. The judgment as to the significance or otherwise of the matters raised in the consultation is very much a matter for assessment by the clinician with the responsibility of conducting his/her enquiries with the applicant face to face. …'
>
> In relation to Classes of PIRS there has to be more than a difference of opinion on a subject about which reasonable minds may differ to establish error in the statutory sense. (*Ferguson* [24])."

37. The Court said, finding the Panel in that matter erred in equating a difference of opinion with a demonstrable error at [70],

> "To find an error in the statutory sense, the Appeal Panel's task was to determine whether the AMS had incorrectly applied the relevant Guidelines including the PIRS Guidelines issued by WorkCover. Even though the descriptors in Class 3 are examples not intended to be exclusive and are subject to variables outlined earlier, the AMS applied Class 3. The Appeal Panel determined that the AMS had erred in assessing Class 3 because the proper application of the Class 2 mild impairment is the more appropriate one on the history taken by the AMS and the available evidence."

38. The appellant submits that the AMS erred in accepting the history of the respondent worker on these PIRS Categories. The Panel rejects this submission. The AMS is in the best position to assess the reliability of the history given. The AMS does not say Ms Doulman is an unreliable historian. He was aware of Ms Moodley's opinion about Ms Doulman and says that he does not agree with it.

39. The appellant submits that Dr Oldtree Clark's history about the marital relationship should have been accepted by the AMS. The AMS is not obliged to accept any of the assessors relied on but is obliged to use his clinical expertise as confirmed in *Parker*. A difference of opinion does not constitute an error on the face of the Certificate. In *Mahenthirarasa v State*

Rail Authority of New South Wales & Ors [2007] NSWSC 22 the Court said: "A demonstrable error would essentially be an error for which there is no information or material to support the finding made – rather than a difference of opinion."

40. The AMS had the evidence of Ms Doulman and the materials before him upon which he based his conclusions. He explains his Social functioning Category rating of Class 2 at Table 11.8,

> "Ms Doulman said she and her husband don't fight. They get along together okay but she is much more withdrawn from him and dependent on him to maintain their relationship. She has no interest in their intimate life. She attempts to maintain contact with the wider family via the telephone."

41. For Employability, the AMS explains the Class 5 rating,

> "Ms Doulman said she becomes anxious even thinking about the idea of trying to work. She can feel her chest tightening. She said she tires very easily and her capacity is small. She does not believe she can do any form of work because her anxiety would be easily set off and she would have to withdraw. In my opinion she is unable to work."

42. The Panel does not accept that the AMS erred in taking a history from Ms Doulman regarding the contested PIRS Categories. The assessment in both Categories was open to the AMS and there is no demonstrable error on the face of the Certificate.

Findings

43. The Panel discerns no demonstrable error on the face of the Certificate. The AMS has used the correct criteria from the SIRA Guidelines, and correctly assessed the deduction for the pre-existing condition.

44. For these reasons, the Appeal Panel has determined that the MAC issued on 7 September 2020 is confirmed.

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*.

H Mistry

Heena Mistry
Dispute Services Officer
As delegate of the Registrar