WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-6427/19**
Appellant:	**Trustees of the Marist Brothers**
Respondent:	**Anthony Phelan Riordan**
Date of Decision:	**25 May 2020**
Citation:	**[2020] NSWWCCMA 92**

Appeal Panel:	
Arbitrator:	**Carolyn Rimmer**
Approved Medical Specialist:	**Dr Lana Kossoff**
Approved Medical Specialist:	**Dr Patrick Morris**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 5 March 2020 the Trustees of the Marist Brothers (the appellant) made an application to appeal against a medical assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission). The appellant was insured at the relevant time by Catholic Church Insurances Limited. The medical assessment was made by Dr Ash Takyar, Approved Medical Specialist (the AMS) and issued on 7 February 2020.

2. The respondent to the appeal is Anthony Phelan Riordan (Mr Riordan).

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 Riordan developed a primary psychiatric injury in the course of his employment as an administrative assistant when on 10 November 2014 he discovered the body of a 13 year old male student who had committed suicide in a bathroom cubicle.

9. The matter was referred to the AMS, Dr Takyar, on 2 January 2020 for assessment of whole person impairment (WPI) of Mr Riordan's psychological/psychiatric disorder attributable to the injury on10 November 2014.

10. The AMS examined Mr Riordan on 15 January 2020 and assessed 22% WPI in respect of the psychological/psychiatric disorder as a result of the injury on 3 June 2004. The AMS made no deduction pursuant to s 323 of the 1998 Act for pre-existing injury, condition or abnormality.

PRELIMINARY REVIEW

11. 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.

12. 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.

13. The appellant did not request that Mr Riordan be re-examined by an Approved Medical Specialist, who is a member of the Appeal Panel.

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

EVIDENCE

Documentary evidence

15. 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

16. 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

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

18. The appellant's submissions include the following:

- The AMS failed to make a deduction for pre-existing injury, abnormality or condition under s 323 of the 1998 Act and a deduction of 1/10th was required on the evidence.

- The AMS made a diagnosis of post-traumatic stress disorder (PTSD) and assessed 22% WPI in respect of the injury on 10 November 2014. The AMS declined to make any deduction under s 323 of the 1998 Act and determined that no deduction for pre-existing condition was required as Mr Riordan was in remission with normal psychosocial and occupational functioning before the injury.

- The AMS fell into error as defined by s 327(3)(c) and (d) of the 1998 Act, in concluding that no deduction under s 323 was required in light of the worker's pre-existing psychological condition.

- There did not appear to be any issue that Mr Riordan suffered a pre-existing injury, abnormality or condition within the meaning of s 323 of the 1998 Act, in the nature of depression (major depressive disorder) and anxiety. Mr Riordan was continuing to be prescribed with antidepressant medication at the time of the injury.

- A deduction under s 323 was not required merely because there is a pre-existing condition. It was necessary that the pre-existing condition 'contributed' to the impairment assessed (*Cole v Wenaline Pty Limited* [2010] NSWSC 78).

- Simply because the pre-existing condition was asymptomatic did not mean that no deduction should be applied (*Vitaz v Westform (NSW) Pty Ltd* [2011] NSWCA 254 at [43]. However, in a case of psychological injury, the worker's ability to function in each of the Psychiatric Impairment Rating Scale (PIRS) categories is required to be assessed in order to calculate the deduction (Clause 11.10 of the Guidelines).

- The evidence, properly considered, supports that the pre-existing condition did contribute to the permanent impairment assessed, and required a deduction of 1/10th pursuant to s 323(2).

- The medical evidence that was before the AMS was all to the effect that the pre-existing condition had contributed to the current condition:

  (a) Dr Greenwood recorded that the previous condition had been "exacerbated" by the work incident and concluded "I find that he suffers Major Depression which has taken quite a shock with the suicide at the school".

  (b) Dr Roberts concluded that the pre-existing depressive state "would be contributory to Mr Riordan's current presentation" and applied a deduction of 1/10th.

  (c) Dr Robertson similarly noted that the worker "describes a pre-existing depressive illness that likely had symptomatic persistence at the date of injury" and that the work injury " exacerbated his underlying constitutional depressive disorder." He too made a deduction of 1/10th.

- Those opinions did not suggest some prior, resolved depressive condition, totally unrelated to the current injury. Rather, they suggested that the current injury was directly superimposed on that pre-existing condition, which Mr Riordan's own expert determined had 'symptomatic persistence' at the time of the injury.

- Whilst the AMS is not strictly bound by the opinions or conclusions of the other experts in the case, in circumstances where both experts (relied upon by the worker and the employer) agree that the pre-existing condition was such as to warrant a deduction, the appellant submits that the AMS was in error to conclude otherwise.

- The AMS noted that his conclusion was based on a 'retrospective' history obtained from Mr Riordan (page 6). Such a history provided over five years post the date of injury, should not of itself have been determinative, yet the AMS relied (it seems) solely on Mr Riordan's report as to his level of functioning before the injury. Whilst this is no doubt a relevant consideration, that subjective history should not have been treated as determinative in light of the medical evidence in the case, including from the treating specialist which was directly contemporaneous to the injury itself.

- The comments of the AMS appeared to suggest that the condition was only in remission "while he was maintained on an antidepressant." (page 7). That is, the condition itself was not in remission, but rather the treatment he was receiving was keeping symptoms under control. That is a significant distinction, as it suggests that he was still suffering ongoing effects from the pre-existing depression, which were controlled by the medication.

- The evidence supported that the pre-existing condition contributed to the impairment assessed, and that s 323 was therefore engaged. The evidence supported that 1/10th was an appropriate deduction (Dr Roberts and Dr Robertson agree with such a conclusion).

- The AMS examined Mr Riordan over five years after the work injury occurred and obviously did not have the opportunity to examine him prior to the injury. In circumstances where Mr Riordan was clearly suffering from ongoing depression at the time of the work injury and being treated for that depression (which would necessarily require ongoing consultation with a doctor), the history recorded by the AMS was not sufficient to conclude as a matter of fact that there was no impairment of function arising from that pre-existing condition. Mr Riordan may have been functioning relatively normally, including working full time, however, to conclude that there was no impairment whatsoever would simply be too difficult to determine retrospectively.

- There was no evidence before the AMS completed before the work injury addressing the extent of the pre-existing condition. However, this is specifically a matter recorded in s 323(2) - 'absence of medical evidence' - where it will be 'too difficult' to determine the extent of the deduction.

- In the circumstances, and in light of the medical evidence before him, the AMS should have concluded that there was some degree of pre-existing impairment present and some contribution from the pre-existing condition, however the exact contribution and deduction was 'too difficult' to determine in accordance with s 323(2).

- Once it is determined that the deduction is too difficult to determine, the deduction 'is to be assumed' to be 1/10th (s 323(2)). The AMS was therefore statutorily required to assume that deduction. As 1/10th was clearly not at odds with the evidence (as both experts in the case agreed on that deduction), a 1/10th deduction should have been applied.

- The AMS was in error to determine that no deduction under s 323 of the 1998 Act should be applied.

- The MAC should be revoked, and a 1/10th deduction applied under s 323 of the 1998 Act, resulting in a final assessment of 20% WPI due to injury on 10 November 2020.

19. Mr Riordan's submissions include the following:

- The AMS has correctly applied the law, and correctly found that there is no justification for a deduction for previous injury, or pre-existing condition or abnormality pursuant to s 323 of the 1998 Act.

- The MAC did not contain a demonstrable error as the AMS' conclusions were open to him on all of the evidence before him.

- The exercise to be engaged in by the AMS when determining the question of what proportion of the impairment was due to previous injury, pre-existing condition or abnormality was an evaluative exercise having regard to all evidence properly before the decision maker (*State of New South Wales v Hill* [2018] NSWSC 541, per Campbell J at [49]).

- The AMS carried out the evaluative exercise in accordance with the correct legal principles, legislation and applicable guidelines. He identified the previous injury, and then set out and considered the actual consequences of it. The AMS applied his expertise, and his clinical skill and judgment to conclude that no deduction ought to be made.

- When assessing impairment resulting from a psychological injury, clause 11.10 of the Guidelines requires an AMS to engage in a prescribed exercise when measuring the impairment caused by a work-related psychological injury. The AMS is also required (by use of the word must) to measure the proportion of the WPI due to the pre-existing psychological condition by using the same method for calculating the current impairment level. It is only if the impairment cannot be assessed that the 1/10th statutory deduction pursuant to s 323(2) is applied. Clause 11.10 is not inconsistent with s 323 but is an additional requirement to be undertaken by the AMS.

- The AMS stated at [9] of the MAC that his assessment of WPI was based on "[T]he mental state examination, clinical history and review of medical documentation". He had before him all of the evidentiary materials relied upon by the parties. It can be accepted that the AMS considered all of the relevant evidence that was before him, because he stated that he had and it is a well-established principle that a beneficial constriction is given to the reasons for decision of an administrative decision-maker (*Minister for Immigration and Ethnic Affairs v Wu Shan Liang* (1996) 185 CLR 259; [1996] HCA 6).

- The AMS carried out his task in accordance with the applicable guidelines. He explained his conclusions at pages 6 and 7 of the MAC and explained the reasons why he made no deduction. The AMS explained that in applying clause 11.10 to the measurement of the pre-existing impairment, there was no impairment as he was functioning normally. The AMS was well aware of the medication and the prior episodes of depression. These are extensively referred to at pages 9 and 10 of the MAC. The AMS did not rely only on the self-report of Mr Riordan. It is clear that he had regard to the correct history of the prior episodes and to the medication Mr Riordan was continuing to take which he was prescribed by a general practitioner.

- The AMS provided a clear and intelligible rationale for his findings as required by the relevant guidelines and the law. There is a clear and reasoned explanation for his conclusion as to whether to make any deduction. He exposed his reasoning process as required by a decision maker. He did not apply incorrect criteria and he considered all of the relevant evidence.

- There is no demonstrable error contained in the MAC or the statement of reasons.

- The appellant asserts that the AMS ought to have made a deduction because Mr Riordan's medico-legal specialist, Associate Professor Robertson, made a 1/10th deduction. The AMS explained why he disagreed with that opinion at length at [10a] of the MAC.

- The Court of Appeal dealt with the distinction between an error and a disagreement of opinion in *Vannini v Worldwide Demolitions Pty Ltd* [2018] NSWCA 324 at [87] (*Vannini*), where it said that 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". The finding of the AMS not to apply a deduction was open to him on the evidence. The appellant's assertion that a deduction ought to be applied because Associate Professor Robertson applied one was misconceived and wrong in law.

- For the reasons set out in these submissions, the Appeal Panel should not to find any error in the MAC and should confirm the MAC.

- If the Appeal Panel finds error, a re-examination would be required.

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.

22. 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.

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

Discussion

24. 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.

25. In the MAC, under "History relating to the injury", the AMS recorded:

> "He was initially treated by A/Prof James Greenwood who was funded by the insurer. He said that he was seen for around a year at a varying frequency. He said that he had already been prescribed venlafaxine XR 75 mg from a previous depressive episode, even though he was in near-full remission and functioning normally. He said that the dose was then increased to 150 mg and then by about May 2015 to 300 mg (150 mg twice per day)."

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

> "Mr Riordan reported that he had been diagnosed with depression in 1994 after he was retrenched from AGC and he was commenced on venlafaxine XR 75 mg, saw an EAP counsellor three times and a psychologist three times. He remained on the medication after he recovered. He said that in 2006, after his daughter was admitted to hospital for anorexia nervosa, he became unwell for 2-4 weeks. However, he said that after four weeks he was 'straight back to work, fully functioning**'.** He remained on the same dose of venlafaxine XR. He said that he remained on the same dose until the injury.
>
> He said that despite this, his mood was roughly normal before the injury (6-7/10, where 1 is most depressed, 10 most elated and 7-8 reflect euthymic mood). He said that his energy levels were normal, he had normal enjoyment and normal concentration and memory and that he was able to manage working as a facilities manager for a large school. He said that he had no anxiety. He described scuba-diving, bushwalking and watching rugby union on a regular basis, and he told me that he travelled with his rugby union club (Eastwood) all over Sydney for Saturday matches. He said that he also coached the St Joseph's 15Ds rugby team. He said that he saw friends two or three times a week."

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

> "Mr Anthony Riordan is a 59-year-old male who has a prior psychiatric history of two discrete episodes of major depressive disorder. He was in full remission on Efexor 75 mg at the time of the work injury occurring. On obtaining a retrospective history of his symptoms before the subject work injury, he described normal sleep of 8-9 hours a night, normal concentration and memory in a busy job at a large school, normal energy and enjoyment, appetite of three meals a day and no anxiety. He said that his mood was essentially normal (rated at 6-7/10, where 1 is most depressed, 7-8 reflect euthymic mood and 10 is most elated). He was bushwalking fortnightly, scuba-diving every two months and travelling every Saturday with the rugby union team he followed as well as coaching rugby union at school. His functioning, therefore, reflected no impairment. He was functioning normally in regard to social and recreational activities, had no difficulties socialising by himself with friends, was bathing every day, eating three meals a day and attending to hygiene matters well.

> He was travelling where required without difficulty. He had no difficulties with his marriage or friendships. His concentration was normal and he would read for two or three hours at a time and watch television or movies without difficulty. He was able to work full-time.
>
> It is my view, therefore, that while he was maintained on an antidepressant, he was in full remission on that antidepressant and my review of his history indicates that there was no dysfunction or impact from that previous depression on his functioning pre-injury.
>
> Subsequent to the traumatic nature of the injury occurring at St Joseph's College, he has experienced a decline in his mental state and a range of symptoms including hyperarousal symptoms, anxiety, hypervigilance, re-experiencing phenomena, depressive cognitions and changes and avoidance phenomena. This is consistent with a DSM-5 diagnosis of post-traumatic stress disorder attributable to the work injury."

28. The AMS on page 7 of the MAC in answer to the question "Is any proportion of loss of efficient use or impairment or whole person impairment, due to a previous injury, pre-existing condition or abnormality?" wrote:

> "No, it is not – he had a pre-existing history of two depressive episodes but the last episode occurred in around 2006 and lasted for 2-4 weeks. He remained on a very low dose of his antidepressant and was in remission with normal psychosocial and occupational functioning before the injury. There is, therefore, no pre-existing impairment."

29. The Appeal Panel noted that Associate Professor Robertson, made a 1/10th deduction in his assessment of Mr Riordan. The AMS explained why he disagreed with that opinion at length at page 8 of the MAC:

> "I do not agree with the one-tenth deduction for previous depression that he provided and that Dr Roberts provided in his report of 22.02.2019, because although Mr Riordan was prescribed an antidepressant before the work injury, he had been enjoying normal sleep of 8-9 hours a night, normal appetite of three meals a day, normal concentration and memory in a busy job, normal enjoyment and energy, had no self-harm or suicidal ideation, had no anxiety and his mood was about normal (he rated it at 6-7/10, which is essentially normal). His functioning was normal and he was scuba-diving every two months, bushwalking fortnightly and travelling every Saturday to see his rugby union team. He coached rugby union as well. His functioning psychosocially and occupationally was normal. There was no evidence of any impairment prior to the injury. Therefore, I have not provided a deduction for prior illness. I also note that it was in 2006 that his last depressive relapse happened, which lasted for 2-4 weeks before he returned to normal functioning."

30. The appellant submitted that the AMS failed to make a deduction for pre-existing injury, abnormality or condition under s 323 of the 1998 Act and a deduction of 1/10th was required on the evidence. The appellant referred to various reports of Associate Professor Greenwood, Dr Roberts and Associate Professor Robertson.

31. The Appeal Panel reviewed the evidence in the matter.

32. Associate Professor Greenwood, treating specialist, in a report dated 21 November 2014 wrote:

> "He had some exacerbation of his depressive symptoms with mood depression, anxiety and sleep difficulties. However, his medication of Efexor 75mg daily which you increased to 150mg daily had contained other depressive symptoms. He reported that he had not received psychiatric treatment for his condition which had been present for many years. His various GPs had prescribed Efexor which he continued to take regularly with benefit."

33. Associate Professor Greenwood then noted various familial and personal issues and concluded:

> "I found that he suffers Major Depression which has taken quite a shock with the suicide at the school."

34. In a further report of 19 January 2015, Associate Professor Greenwood noted that the worker had suffered "Depression for a number of years but had been able to stay on top of it until this episode. Since that experience he became severely depressed…"

35. Dr Greenwood in a report dated 12 May 2015 wrote:

> "He had suffered depression at times in the past and had received antidepressant medication which had been helpful from his GP. However, he had not had previous psychiatric treatment or counselling for bis problem which had been stable for some years. He had been taking an antidepressant medication, Efexor XR 75mg daily, which he had continued as a regular medication. The events of this present time precipitated a severe downturn in his mental state and he required leave from his duties for a month, then a gradual return to work subsequently.
>
> He was able to work full-time from the beginning of the school term in January 2015 but was still seriously affected by the prior trauma. He has needed regular counselling for the trauma and the subsequent depression and he has required a significant elevation in his medication which at present dosage is Efexor XR 150mg twice daily, three times the dose that had maintained him previously.
>
> …
>
> His domestic situation was adversely affected by his illness, as would be expected."

36. Dr John Albert Roberts, psychiatrist, provided several reports for the appellant. In his report of 15 December 2018 (on page 8), Dr Roberts wrote:

> "In regard to other matters Mr Riordan commented on his father as having been an alcoholic that his paternal grandmother suicided that depression had not stopped him working and that he had coached sports. He referred to having had a problem with a neighbour who was a stalker and of that being a factor in moving to Sydney; that his daughter had a history of unwellness that this was some 10 years ago, of her now being well and of being married to a person whom he described 'a lovely Jewish man' that his daughter was working as a music writer, she does not have a family due to the presence of endometriosis.
>
> Mr Riordan commented that he felt grief in regard to what he has lost, he referred to his wife as having lost family I presume he implied contact with family; that he experienced what he referred to as 'rolling depression' that his general practitioner had suggested that he have his medication reviewed."

37. Dr Roberts wrote on pages 11-12:

> "I note certain medical records from the Hunters Hill Medical Practice as of 7.11.2017. I note that under the heading Past Medical History, reference is made in 1994 to the presence of depression and of his back problems of 2016 and 17.
>
> I note an entry 22.3.2017 in which reference is made to tremulousness, hypervigilant and interest, relapse when daughter became anorexic, saw a psychiatrist then, two weeks off work then otherwise always was employed.
>
> I note consultations on 6 December 2016 with Dr Charbel Bagr which makes reference to of Efexor two years since the critical incident at the school – child suicide, still has some thoughts re this, poor concentration."

38. Dr Roberts made a diagnosis of pre-existing recurrent major depression and PTSD. On page 13, he wrote:

> "I consider that in regard to the development of the claimed disability if such is assumed that Mr Riordan was rendered vulnerable to the development of a mental illness in later life by virtue of his pre-existing major depression and family history."

39. Dr Roberts on page 14 wrote:

> "I note that you make reference to certain factors in Mr Riordan's history namely of his father being an alcoholic and of being violent and displaying reckless behaviour when drunk, of the suicide of his grandmother, of a previous history of depression in the 1990's, of him and his wife living on the South Coast for 16 years but leaving due to being stalked by a mentally ill neighbour - when this was raised with Mr Riordan he commented that he moved because of concern in regard to his wife and daughter and of his daughter suffering from anorexia.
>
> COMMENT: All of the above constitute a relevant psychiatric history which would indicate vulnerability and his previous depressive state and concern in regard to his daughter suffering from anorexia would indicate that factors other than the death of the lad would be contributory to Mr Riordan's current presentation."

40. In a report of 22 February 2019, Dr Roberts wrote:

> "I refer to my report of 28 March 2017 page (4) continuing from page (3) under the heading Past Psychiatric; History, I noted, 'When questioned as to whether, prior to this matter, he had ever attended upon a psychologist, psychiatrist, counsellor or general practitioner for the treatment of any nervous condition, Mr Riordan stated that in 1994 he had attended his then general practitioner in the context of a major retrenchment from AGC that he was prescribed Efexor 75mgs at that time. In 2007 he attended an Employees Assistance Program on three occasions; that he also in 2007 saw a lady namely a psychologist whom he saw once a month on three occasions, no other psychiatric history is described until the injury being (the subject of this matter)'.
>
> I note that I considered Mr Anthony Phelan Riordan's response to the circumstances under consideration an unusual and disproportionately severe response to the stressor but not an impossible response.

If it is assumed that his response is true and accurate, a pre-existing vulnerability would be a matter for consideration.

I would consider that in regard to the history given by Mr Riordan in regard to predate of subject injury psychopathology, if his overall dysfunctionality would be mild - a deduction of 10% for pre-existing pathology would be appropriate which would reduce his overall level of impairment from 21% to 19%."

41. Associate Professor Michael Robertson, in a report dated 22 November 2017. noted on page 7 that:

"Mr Riordan volunteered a previous history of depression. His indexed episode of depression occurred in the early 1990s, when he was made redundant amidst the economic downturn. He was unwell for a period of at least four to five months and seemed to have responded well to treatment with a tricyclic antidepressant.

A second episode of depression in 2006 seemed to be brought about by his daughter's admission to hospital with anorexia nervosa. He was unwell for a period of two-four weeks.

There is also evidence of further periods of intermittent dysphoria necessitating occasional interactions with therapists or EAP."

42. Under Assessment Associate Professor Robertson wrote:

"Mr Riordan is a 57-year-old man who sustained traumatic stress exposure on 10 November 2014 after finding the body of a student who had hanged himself. He experienced an acute state of psychological distress, although he returned to employment, and suffered a progressive decline in his mental health over the next 12 months. He ceased duties as a consequence of worsened depression, complicated by failed back surgery with post-operative complications, and problems in the handling of his workers' compensation claim.

His depressive symptoms had responded to high doses of venlafaxine, which seemed to give way to a more florid manifestation of post-traumatic stress disorder characterised by the pathognomonic symptoms of nightmares and flashbacks, hyperarousal, hypervigilance, trauma specific phobias, an exaggerated startle reflex, cognitive impairment and social withdrawal.

A prominent clinical feature of Mr Riordan's presentation has been dissociative symptoms, manifesting as emotional numbing and episodes of derealisation. These were evident at the interview today.

Mr Riordan described his treatment by Professor Greenwood as focusing specifically on the management of his depression, which appeared to be the primary clinical problem.

When I asked Mr Riordan to elaborate on some of the frustrations he experienced with Professor Greenwood's care, he nominated that Professor Greenwood was more interested in focusing on 'here and now' and supporting him. This combined with judicious modification of his antidepressant medication represents entirely reasonable treatment from my perspective, particularly given Mr Riordan's previous presentation of depression and the likelihood that intra-therapy traumatisation through constant focusing on traumatic events would likely destabilise his mental

state and also interfere with the clinical relationship. In fairness to Professor Greenwood, it appears that Mr Riordan's post-traumatic stress disorder symptoms were not more clinically apparent until sometime after the event. This is potentially explicable in terms of Mr Riordan's constitutional depressive disorder being exacerbated as a consequence of the tragic events of 10 November 2014, which masked an evolving post-traumatic stress disorder."

43. Associate Professor Robertson on page 10 expressed the view that the traumatic stressor encountered in his employment with St Joseph's College exacerbated Mr Riordan's underlying constitutional depressive disorder and was the substantial contributing factor to the onset of PTSD. He commented that the two conditions were co-morbidly present, although the depressive illness had improved under Professor Greenwood's care. Associate Professor Robertson noted that Mr Riordan presented with a chronic persistence of his PTSD particularly with dissociative symptoms. He noted on page 11 that the pre-existing depressive illness was exacerbated by the incident on 10 November 2014, and that the pre-existing condition improved with appropriate antidepressant treatment which had the "paradoxical effect of leading to a more florid manifestation of PTSD that was either overshadowed or obscured by his depressive illness or perhaps had a delayed onset."

44. In his report dated 26 September 2018, Associate Professor Robertson provided his assessment of WPI and commented at page 8:

> "Mr Riordan describes a pre-existing depressive illness that likely had symptomatic persistence at the date of injury. I believe as a result, there are grounds for a deduction under Section 323 of the Act. The best methodology in the circumstances is a one tenth deduction."

45. The Appeal Panel also noted the report from Dr Selwyn Smith, treating psychiatrist, dated 17 March 2017. Dr Smith wrote:

> "Anthony reported that in November 2014 he was referred to Dr Jim Greenwood against a background of his attendance at a suicide at the school. A 13 year old boy had hung himself in the toilet cubicle. The impact on him was significant. From the history at hand he developed diagnostic criteria for a Post-Traumatic Stress Disorder. He reported that he was not particularly helped by Dr Greenwood. He has been utilising Efexor XR in a dosage of 200mg per day as well as Temaze 10mg at night. He recently ceased that utilisation of Temaze and found it difficult to sleep. He has continued to ruminate about his adverse work related experience."

46. 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*).
>
> 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.
>
> 83. The 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.

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].

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."

47. 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."

48. 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."

49. In *Cullen v Woodbrae Holdings Pty Ltd* [2015] NSWSC 1416 the Court reiterated the need for evidence of an actual pre-existing condition rather than a predisposition or susceptibility,

50. 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."

51. As noted above, the appellant submitted that the AMS failed to make a deduction for pre-existing injury, abnormality or condition under s 323 of the 1998 Act and that a deduction of 1/10th was required on the evidence.

52. The Appeal Panel noted that the primary diagnosis was PTSD. Associate Professor Robertson made a diagnosis of dissociative PTSD, which is a more severe form of PTSD. The Appeal Panel noted that the event on 10 November 2014 was horrific and Mr Riordan told the AMS that he had stayed at the scene for several hours after he discovered the body.

53. The Appeal Panel accepts that Mr Riordan had a history of pre-existing episodes of depression and was on a small dosage of an antidepressant when the injury occurred on 10 November 2014. However, the Appeal Panel noted that the last episode of depression prior to the subject injury occurred in around 2006 and lasted a relatively short time, namely, two-four weeks. It appeared that Mr Riordan had no symptoms of depression when the subject injury occurred on 10 November 2014.

54. The Appeal Panel noted that neither Dr Roberts nor Associate Professor Robertson referred to clause 11.10 of the Guidelines and neither doctor stated that the percentage of pre-existing impairment could not be assessed. Neither Dr Roberts nor Associate Professor Robertson addressed in detail Mr Riordan's pre-injury level of functioning in each of the PIRS categories.

55. The AMS properly considered in some detail the various areas of functioning, both pre-injury and on the day of examination. The AMS was of the view that Mr Riordan was in full remission "on Efexor 75 mg" with normal psychosocial and occupational functioning before the injury on 10 November 2014.

56. The AMS obtained a retrospective history of Mr Riordan's symptoms before the subject injury, and reported the following:

> "…he described normal sleep of 8-9 hours a night, normal concentration and memory in a busy job at a large school, normal energy and enjoyment, appetite of three meals a day and no anxiety. He said that his mood was essentially normal (rated at 6-7/10, where 1 is most depressed, 7-8 reflect euthymic mood

> and 10 is most elated). He was bushwalking fortnightly, scuba-diving every two months and travelling every Saturday with the rugby union team he followed as well as coaching rugby union at school. His functioning, therefore, reflected no impairment. He was functioning normally in regard to social and recreational activities, had no difficulties socialising by himself with friends, was bathing every day, eating three meals a day and attending to hygiene matters well. He was travelling where required without difficulty. He had no difficulties with his marriage or friendships. His concentration was normal and he would read for two or three hours at a time and watch television or movies without difficulty. He was able to work full-time."

57. The AMS formed the view that while Mr Riordan was maintained on an antidepressant, he was in full remission on that antidepressant and the review of his history indicated that there was no dysfunction or impact from that previous depression on his functioning pre-injury. The AMS concluded that there was no evidence of any impairment prior to the subject injury.

58. The Appeal Panel considered that the retrospective history of symptoms and functioning obtained by the AMS, amounted to an assessment of the different PIRS classes. It was clear, in the view of the Appeal Panel, that based on that history taken by the AMS that the assessment of WPI pre-injury would have been 0% WPI. The Appeal Panel was satisfied that in this case the pre-existing episodes of depression did not cause or contribute to the assessed WPI caused by the PTSD. The Appeal Panel agreed with the AMS that it was subsequent to the traumatic nature of the injury occurring at St Joseph's College, that Mr Riordan experienced a decline in his mental state and a range of symptoms including hyperarousal symptoms, anxiety, hypervigilance, re-experiencing phenomena, depressive cognitions and changes and avoidance phenomena. This decline and the symptoms were consistent with the diagnosis of PTSD attributable to the work injury.

59. The Appeal Panel noted that Dr Roberts did not take a detailed history of functioning before the subject injury. Dr Roberts appeared to simply conclude that there was a relevant psychiatric history which would indicate vulnerability and the previous depressive state and concern in regard to his daughter suffering from anorexia would indicate that factors other than "the death of the lad would be contributory to Mr Riordan's current presentation". Dr Roberts went on to note that a pre-existing vulnerability would be a matter for consideration. As noted above, a deduction pursuant to s 323 of the 1998 Act cannot be made in respect of a vulnerability.

60. Dr Roberts considered that in regard to the history given by Mr Riordan predating the subject injury psychopathology, the overall dysfunctionality would be mild and a deduction of 10% for pre-existing pathology would be appropriate. However, Dr Roberts did not actually consider the level of functioning in the different PIRs classes pre-injury as required in the Guidelines.

61. The Appeal Panel noted that Associate Professor Robertson applied the incorrect methodology in making a deduction for a pre-existing condition in his assessment of impairment. Associate Professor Robertson simply concluded that the pre-existing depressive illness likely had symptomatic persistence at the date of injury, that is, 10 November 2014. Associate Professor Robertson did not refer to the level of functioning in the various PIRS categories pre-injury or consider whether the pre-existing injury or condition, on the available evidence, caused or contributed to the assessed WPI..

62. The Appeal Panel considered that the AMS carried out his task in accordance with the Guidelines and explained in detail the reasons why he made no deduction under s 323 of the 1998 Act. The Appeal Panel was satisfied that the AMS did not apply incorrect criteria and he considered all of the relevant evidence.

63. The Appeal Panel does not accept the submission that a deduction ought to be applied because Associate Professor Robertson and Dr Roberts applied one. The AMS explained in detail why he disagreed with the deduction made by Associate Professor Robertson. There is a distinction between an error and a disagreement of opinion. In *Vannini* at [87], the Court of Appeal said that 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". The finding of the AMS not to apply a deduction was open to him on the evidence and it was a finding with which the Appeal Panel agreed.

64. In conclusion, the Appeal Panel did not consider that there has been an incorrect application of relevant assessment criteria, that is, the Guidelines or any demonstrable error in the AMS' assessment.

65. For these reasons, the Appeal Panel has determined that the MAC issued on 7 February 2020 should be 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*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar