CITATION: *Phillip Banks v Andersfurn Pty Ltd* [2014] NTMC 027

PARTIES:	PHILLIP BANKS
	v
	ANDERSFURN PTY LTD (ACN 122 510 909)
TITLE OF COURT:	Work Health Court
JURISDICTION:	Work Health
FILE NO(s):	21126178
DELIVERED ON:	11 November 2014
DELIVERED AT:	Darwin
HEARING DATE(s):	25 February to 1 March 2013, 27 March, 26 April 2013, 8 May, 17 May 2013
JUDGMENT OF:	JMR Neill

CATCHWORDS:

WORK HEALTH – BURDEN AND STANDARD OF PROOF IN RELATION TO CONSEQUENTIAL INJURIES – ADMISSIBILITY AND WEIGHT OF EXPERT EVIDENCE - CAUSATION

Newton v Masonic Homes [2009] NTSC 51 applied
Makita (Australia) Pty Ltd v Sprowles (2001) 52 NSWLR 705 applied
McLean v Commonwealth (unreported NSW Court of Appeal 31 December 1996) applied

REPRESENTATION:

Counsel:

Worker:	Kerry Sibley
Employer:	Duncan McConnel

Solicitors:

Worker:	Priestleys
Defendant:	Hunt & Hunt

Judgment category classification:	B
Judgment ID number:	027
Number of paragraphs:	109

IN THE COURT OF
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 21126178

BETWEEN:

PHILLIP BANKS
Worker

AND:

ANDERSFURN PTY LTD
Employer

REASONS FOR JUDGMENT

(Delivered 11 November 2014)

John Neill SM:

Introduction

1. The Worker Phillip Banks was born on 1 December 1968 and is presently aged 45 years.

2. It is common ground between the parties that Mr Banks suffered a back injury as the result of a fall in the course of his employment with the Employer on or about 20 May 2008 ("the injury"). He made a claim under the *Workers Rehabilitation and Compensation Act* ("the Act"). The Employer accepted that claim and commenced making payments of compensation to or on behalf of Mr Banks.

3. Subsequently the parties found themselves in dispute on a number of issues in the context of the accepted claim for compensation. Only three of those issues remained for determination by the commencement of the hearing of these proceedings on 25 February 2013. Those three issues were identified by me as part of my Orders made at a Directions Hearing on 14 February

2013. They were: (i) identification of the Worker's physical injuries and their consequences and their effect on him; (ii) whether the Worker suffers from a Major Depressive Disorder because of the work injury on 20 May 2008; and (iii) whether the Employer owes the Worker any arrears of weekly benefits and/or any interest on any such arrears, calculated over the period 21 May 2008 to the date of payment.

The Pleadings

4. The pleadings at the commencement of the hearing on 25 February 2013 were the Amended Statement of Claim filed 18 February 2013 and the Amended Notice of Defence filed 21 February 2013. These were further amended on the first day of the hearing, with the effect that there was no longer any dispute on the pleadings as to Mr Banks's physical injury ("the physical injury"). The Employer now admitted that on 20 May 2008 Mr Banks suffered an L4/5 disc prolapse with radicular pain in the right leg, and thereafter suffered severe neuropathic pain in the right leg and pain in the region of the right iliac crest and buttock (paragraph 4 of the Amended Defence as further amended in open court on 22 March 2013 – see transcript page 17.1 to 17.5), and that he had suffered injury to his knee, although whether the right or left knee was not specified - see paragraph 6 of the Amended Defence. I note the letter dated 15 March 2012 from lawyers Hunt & Hunt to psychiatrist Dr John Roberts – part of exhibit E6 - which at page 1.8 identifies the right knee as having become "very painful" when he suffered the injury.

5. I find that on 20 May 2008 Mr Banks suffered an injury in the course of his employment with the Employer being an L4/5 disc prolapse with radicular pain in the right leg and an injury to his right knee and that as a consequence of the injury he has suffered severe neuropathic pain in the right leg and pain in the region of the right iliac crest and buttock.

6. The issue of an entitlement to arrears of weekly benefits and interest on those arrears was pleaded but this was resolved during the course of the hearing. On 1 March 2013 I was informed that the arrears were now agreed in the sum of $15,691.74 and that this had been paid on 11 April 2012. I was informed that interest on these arrears was agreed in the sum of $9,000. It is not necessary for the Court to make any orders on this issue.

7. Other issues raised in the Amended Statement of Claim included household services, home modifications and transport costs associated with treatment for the physical injury. These were specifically not proceeded with at the hearing of these proceedings. No evidence as to these issues was adduced at the hearing and I am not called upon to consider these claims in these Reasons.

8. In paragraph 10.4 of the Amended Statement of Claim Mr Banks pleaded: "The Worker has suffered a consequential mental injury namely a Major Depressive Disorder". He did not plead any additional or alternative mental injury. The Employer simply denied this pleading in paragraph 10.4 of its Amended Notice of Defence ("the denial"). In paragraph 10.4.2 the Employer went on to plead in the alternative that if Mr Banks did suffer a Major Depressive Disorder, it was not a result of the work injury.

9. The Employer did not comply with sub rules 8.07(2) and (3) of the *Work Health Court Rules* in that its pleading in paragraph 10.4 of its Defence did not clarify the denial by stating the facts it relied on as the basis of the denial nor did it plead any different facts it intended to prove.

10. However the Employer in its case at the hearing led evidence from psychiatrist Dr John Roberts of his opinion that Mr Banks was feeling depressed as a consequence of the "pain… practical implications of the physical disability on function; result in a circumstance where activity is limited by physical reasons and changes in lifestyle…" arising from the physical injury. The opinion of Dr Roberts was that Mr Banks was

experiencing depression but that this was a reaction to his circumstances arising from his severe neuropathic pain and was a symptom, not a diagnosis. He distinguished this symptom of depression from any formal diagnosis of a depressive illness, and specifically from a Major Depressive Disorder.

11. This opinion is set out on pages 11 and 12 in Dr Roberts's report dated 25 April 2012 - exhibit E6 - which was served on Mr Banks's lawyers on an unspecified date but in any event well before the hearing.

12. Counsel for Mr Banks did not object to the Employer's adducing evidence of this opinion of Dr Roberts on the ground it had not been pleaded, or at all. Ms Sibley cross-examined Dr Roberts on this opinion. Ms Sibley did not raise this pleading point in her final written submissions or indeed at any stage of the proceedings.

13. The Employer ran its case on the basis of the opinion of Dr Roberts that Mr Banks was suffering with the symptom of depression as a reaction to the physical injury and its effects on him rather than from any diagnosable psychiatric condition, specifically the condition of Major Depressive Disorder. This was effectively the Employer's particularisation of the denial pleaded in paragraph 10.4 of the Amended Notice of Defence.

14. In Mr Banks's prayer for relief set out in paragraph 14 of the Amended Statement of Claim he sought a declaration that he had suffered a Major Depressive Disorder (14.5) but he did not seek any consequential relief such as treatment for that Disorder. However, a prayer for relief is not a pleading in the strict sense and this omission is not a bar to any remedy. Any finding that as a consequence of the injury and the physical injury Mr Banks is suffering any depression, either as the specific diagnosis of Major Depressive Disorder as he has claimed or as a reactive symptom as the Employer maintains, will entitle Mr Banks to compensation from the Employer in accordance with the Act. I am not called upon in these

proceedings to order any specific compensation or any remedy other than the declaration sought, and costs. The claim for any sort of interest was resolved as I have noted in paragraph 6. above.

The Issues

15. The issues which remain to be determined are i) whether Mr Banks is suffering a Major Depressive Disorder; if so, ii) whether that condition is a result of the injury and the physical injury; if not so, iii) whether Mr Banks is suffering with the symptom of depression as a reaction to the injury and the physical injury and their effects on him; or iv) whether Mr Banks is not suffering any psychological consequences of the injury and the physical injury at all.

16. If i) is established then it will be necessary also to go on to consider ii). If i) is not established then it will not be necessary to consider ii). It will in that case be necessary to consider iii) and iv).

The Onus

17. Mr Banks's pleading was that the Major Depressive Disorder was "consequential". Counsel for Mr Banks made it clear at the hearing and in final submissions that his claim is for this mental condition having arisen as a consequence of the original injury and the physical injury, not for this mental condition having been directly caused by the original injury and arising at the time of or close to the original injury.

18. The Employer's acceptance of the claim was an acceptance of liability for all Mr Banks's injuries and their consequences arising from the work accident. Nevertheless, the existence of the Major Depressive Disorder and that it is a consequence of the injury and the physical injury must both still be proved on the balance of probabilities. It is not for the Employer to disprove either of these matters. Mr Banks bears both the legal and

evidentiary onus of proving both matters – see per Mildren J in *Newton v Masonic Homes* [2009] NTSC 51 at paragraph [24].

19. If Mr Banks fails to discharge his onus of proving the existence of the Major Depressive Disorder on the balance of probabilities then the evidence must still establish on the balance of probabilities that he suffers from the symptom of depression as raised by the Employer in its case. It does not automatically follow that the absence of the one necessitates the presence of the other.

Treatment for the Injury and the Physical Injury

20. I received and heard evidence about the injury and the physical injury including consequential surgical and medical treatment. This evidence is found in Mr Banks's live evidence and in the evidence of treating doctors, including orthopaedic surgeon Dr B. Nyunt (exhibit W2), specialist rehabilitation physician Dr Gavin Chin (exhibit W4 and Dr Chin's live evidence), and specialist pain management physician Dr Paul Verrills (exhibit W12 and Dr Verrills's live evidence).

21. Mr Banks had surgery to his lower back in an attempt to treat symptoms arising from the injury. More conservative treatment had not been effective. The surgery left Mr Banks with scarring around some nerves where they exited from his spinal cord in his lower back. This left him suffering the severe neuropathic pain accepted as and now found to be part of the physical injury.

22. None of the evidence of this initial surgery and subsequent treatment was contested. Accordingly I find that the relevant treatment history is as follows:

i) 20 May 2008 – back injury through a fall at work;

ii) 18 July 2008 – C.T. guided nerves root block;

iii) 10 September 2008 – decompressive laminectomy at L3/L4 and L4/L5 and rhizolysis (interruption of spinal nerve roots by coagulation with radiofrequency waves);

iv) 13 February 2009 – C.T. guided nerves root block;

v) 2 September 2009 – the first spinal cord stimulator is implanted;

vi) February 2010 – reprogramming of the first spinal cord stimulator;

vii) October 2010 – Mr Banks suffers a fall at home when entering his pool for physiotherapy, causing a fracture associated with L4 vertebra leading to 11 days as a hospital inpatient;

viii) October 2010 - another reprogramming of the spinal cord stimulator;

ix) September 2011 – reduced mobility leading to Mr Banks's needing to use a 4 wheel walker;

x) 1 February 2012 – replacement of the first spinal cord stimulator implant with a newer model – the second spinal cord stimulator implant;

xi) August 2012 – Ketamine infusion;

xii) September 2012 – reprogramming of the second spinal cord stimulator.

23. During the whole of this timeline and up to the hearing commencing on 25 February 2013 Mr Banks was prescribed a number of different medications for his condition of severe neuropathic pain and its effects on his life. This condition and these medications and the history of their being prescribed from time to time are found in the reports of Dr Gavin Chin (exhibit W3) and neither this history nor the identification of the medications prescribed was disputed at the hearing.

24. Accordingly I find that the medications prescribed for Mr Banks to treat the physical injury and its effects from to time and continuing are the following:

panadol; panadeine forte; endone; tramadol; amiltryptyline; lyrica; gabapentin; stilnox; valproate; duloxetrine; epilim; cymbalta; methadone; kapanol; efexor; oxynorm; mexiletine; movicol; diazepam; and seroquel.

Effects on Mr Banks

25. Dr Chin's evidence in summary was that the medications were trialled at different times and in different combinations in an effort to control Mr Banks's pain and muscular spasms and also to help him sleep which he found difficult owing to his severe pain, and also to counteract or reduce some side effects of the medications themselves.

26. Mr Banks gave evidence that since the injury he has lived with and continues to live with severe chronic pain and with the side effects of the medications prescribed for that condition. He gave evidence of fluctuating but generally greatly reduced energy levels. He has reduced mobility as a result of his pain and he needs to use a walking frame for general mobility. The effects of his injuries are physically exhausting. He spends most of his days at rest. He gave evidence that the medications to varying degrees have adversely affected and continue adversely to affect his concentration and physical and mental endurance, and generally they cloud his mental processes. He gave evidence of his weight having ballooned from around 92 kgs before the injury up to 150 kgs, before settling in the range from 120 kgs to 130 kgs. He gave evidence of having suffered and continuing to suffer reduced self-esteem and motivation and pervasive feelings of uselessness and worthlessness.

27. Mr Banks's presentation in the witness box was unusual. For much of the time he stood to give his evidence. From time to time his whole body jerked convulsively and he uttered startling cries of distress. Mr McConnel for the Employer cross-examined Mr Banks at length. He did not traverse Mr Banks's evidence as to his experience from time to time of his physical or mental pain or his symptoms generally. He did not suggest Mr Banks was

exaggerating in his physical presentation during his evidence. Indeed, in the Employer's Written Submissions dated 24 June 2013 in paragraphs 1. to 5. Mr McConnel generally accepted these effects on Mr Banks

28. Accordingly, I accept Mr Banks's evidence as to his levels of pain, his uncontrolled muscular spasms, his reduced energy levels, his reduced mobility, his lack of motivation and feelings of uselessness and worthlessness and his symptoms generally, from time to time, all arising from the injury and the physical injury. I accept the evidence of Dr Chin. I make findings in terms of these matters as set out in paragraphs 26, 27 and 28 above.

Use of Late Disclosed Medical Reports of Dr Frost

29. Mr Banks's treating psychiatrist was Dr Mary Frost and Mr Banks relied upon her report dated 6 October 2011- part of exhibit W15 - for her diagnosis of Major Depressive Disorder. There were other reports of Dr Frost admitted into evidence during the hearing. Mr McConnel for the Employer submitted that I should not give any weight to what he described as "10 written reports of Dr Frost that post-dated the report served and relied upon by the Worker as its expert evidence at trial" – paragraphs 8, 9 and 10 in the Employer's Submissions in Reply dated 9 August 2013.

30. Five of these reports in fact pre-date Dr Frost's report of 6 October 2011 and only the remaining five post-date that report. The five which pre-date plus one dated 14 December 2011 were eventually received as exhibit W20. The remaining four reports dated respectively 3 September 2012, 27 September 2012, 15 November 2012 and 5 December 2012 were eventually received together as exhibit W19.

31. These 10 reports were the subject of an application by Mr Banks's counsel Ms Sibley after the Worker's case had closed. Ms Sibley informed me that the reports had only just been brought to her attention by her instructing

solicitors and she felt she had an obligation to the Court and to the Employer to disclose these documents. Copies were provided to counsel for the Employer at this time.

32. The Worker's application was to be allowed to re-open his case and tender these 10 reports in evidence. The Employer opposed receiving these reports into evidence. In preliminary discussion before me Mr McConnel for the Employer foreshadowed the submission that some of the material in these reports had not been put to Dr Frost or Dr Roberts. He said that admitting them, or some of them, might require recalling Dr Roberts who had already given evidence by consent in the course of the Worker's case, and recalling Dr Frost and possibly other witnesses, so that they could be examined on the import of the later symptoms recorded as having been displayed by Mr Banks.

33. On 16 April 2013 the Employer no longer opposed the admission of the six reports from 2011 - those which subsequently became exhibit W20. I made orders on 26 April 2013 in respect of the four reports from 2012, requiring Mr McConnel to identify the specific contents of any of these four reports which in his submission might necessitate the recalling of witnesses. I ordered the filing of written submissions and I adjourned the Worker's application before me to 8 May 2013 for argument.

34. On 8 May 2013 Mr McConnel formally maintained the Employer's opposition to the tender of Dr Frost's four reports from 2012 but he no longer sought to make any submissions. He did not seek to recall or have recalled any witnesses for further examination or cross-examination arising from the late disclosure of those reports. It was in these circumstances that I made orders allowing the Worker to re-open his case to tender all of the undisclosed reports which became exhibits W19 and W20 respectively, as noted above.

35. I was therefore surprised to receive Mr McConnel's submission in paragraph 12 of his Submissions in Reply dated 9 August 2013 that the Employer "maintains its objection to the subsequent reports of Dr Frost being admitted into evidence…". Mr McConnel was aware those reports had already been admitted into evidence on 8 May 2013 following his forensic decision not to make submissions on their tender and not to seek to have any witnesses recalled.

36. I do not accept Mr McConnel's related submission in the same paragraph 12 that these late disclosed reports, or at least the four of them from 2012, should be accorded no weight. There would be no point in my having allowed these reports into evidence in the foregoing circumstances only to accord them no evidentiary weight. None of these reports was a medico-legal report. None of them contained the diagnosis of Major Depressive Disorder. Nine of the 10 reports were to rehabilitation specialist Dr Gavin Chin keeping him updated as to Mr Banks's progress in his treatment by Dr Frost. The remaining one report was to a dietician seeking his input on the issue of Mr Banks's weight. All of these reports formed part of Mr Banks's ongoing and relevant medical history. They are an integral part of the history of Mr Banks's symptoms and treatment as known to Dr Frost on an ongoing basis and as such are relevant to her evidence at the hearing and to her diagnosis of Mr Banks's psychiatric condition at the time of the hearing. To consider the correctness of that diagnosis in the absence of this material would be artificial and potentially misleading.

Evidence as to Mood/Suicide

37. Mr Banks gave evidence that he saw GP Dr Forrest and complained about sleeplessness because of his pain and said words to the effect that "I just want a day off, I don't want it to go on any more". Mr Banks believed Dr Forrest took this to mean he was suicidal because Dr Forrest referred him to

psychologist Dr Jan Isherwood-Hicks – transcript 25 February 2013 page 26.5 to 26.8.

38. Dr Forrest prescribed sleeping pills. Mr Banks gave evidence he took an overdose of these pills together with wine. He said his words at that time were "I just want to go to sleep and not wake up" – transcript 40.4.

39. Obviously, he eventually did wake up. Mr McConnel cross-examined Mr Banks about this event. Mr Banks said it was a conscious suicide attempt. Mr McConnel suggested the real reason Mr Banks took the extra tablets with the wine was because he was so tired, he really just wanted to sleep. Mr Banks answered "I just wanted a day off, I just wanted it to stop" – transcript pages 80.9 to 81.3.

40. Mrs Tracy Banks in her evidence on 26 February 2013 said her husband told her when he woke up from the effects of the sleeping pills and the wine that he had just wanted to go to sleep "and not wake up" – transcript page 90.9.

41. Neither Mr nor Mrs Banks gave specific evidence of when this event occurred but I note Dr Forrest referred Mr Banks to Dr Isherwood-Hicks by letter dated 31 March 2009 – referred to in letter dated 15 April 2009 from Dr Isherwood-Hicks to Dr Forrest at page106 of the Court Book of Documents. It is likely that it occurred around that time.

42. I am satisfied on the balance of probabilities and I find that this incident involving the sleeping pills and the wine in 2009 was a suicide attempt by Mr Banks.

43. Dr Janette Isherwood-Hicks has been a practising clinical psychologist since 1985 (exhibit W9). She is based in Darwin. Mr Banks first consulted her in relation to his severe neuropathic pain on 8 April 2009. She gave evidence she saw him on 12 or 13 occasions a year over 2009 to 2011. She did not make it clear whether that was over 2 years totalling around 26 consultations or over 3 years totalling around 39 consultations (transcript 27 February

2013 page 173.4), but on the basis of her reports (exhibit W9) I am of the view that around 26 consultations is more likely to be correct. Dr Isherwood-Hicks saw Mr Banks on 3 further occasions in 2012 (report dated 29 January 2013 – part of exhibit W9). Dr Isherwood-Hicks's reports were addressed to the referring GP Dr Keith Forrest and to claims officers at QBE, the Employer's Work Health insurer.

44. Dr Isherwood-Hicks did not record anywhere in exhibit W9 that she had arrived at any formal diagnosis of any psychological problem suffered by Mr Banks. She did not identify any diagnosis in her live evidence. She did express the opinion that Mr Banks was suffering an underlying depressed state in 2009/2010 (transcript 27 February 2013 pages 167.9 and 168.3). She further gave evidence that Mr Banks's mental health had deteriorated by August 2012. She said "he had deteriorated, and he – he, you know, presented as distressed and depressed. He had certainly gone downhill"- transcript 27 February 2013 page 176.9).

45. Specialist rehabilitation physician Dr Gavin Chin treated Mr Banks from 6 March 2009 up to the hearing starting on 25 February 2013. His most recent report before the Court was dated 21 December 2012 (part of exhibit W4). He reported from time to time to other doctors involved in the treatment of Mr Banks, including psychiatrist Dr Mary Frost. Dr Chin did not at any time purport to arrive at any diagnosis of any mental condition suffered by Mr Banks.

46. In his report dated 30 April 2009 to Dr Nyunt Dr Chin reported "He is becoming frustrated and depressed with some reduced motivation and emotional lability".

47. In his report to Dr Nyunt dated 26 May 2009 Dr Chin reported "He is becoming more frustrated and depressed".

48. In about August 2010 Dr Chin said he "…found I needed to get the assistance of a specialist psychiatrist to help me deal with his mental health", so he referred Mr Banks to psychiatrist Dr Mary Frost (transcript 26 February 2013 page 115.8).

49. In his report to Dr Verrills dated 7 March 2012 Dr Chin noted under the heading "Current Problems" the description "Anxiety &/or Depression".

50. In his report to Dr Mary Frost dated 30 October 2012 Dr Chin said "…his mental state and mood continue to decline and **he is at a very high suicide risk** (my emphasis)". Dr Chin went on in that report to note "he still has significant depression and limited ability to cope".

51. In his report to Dr Frost dated 21 December 2012 Dr Chin noted a report by Mr Banks that he had become agitated recently at his son's school concert and expressed "**suicidal ideations** (my emphasis)".

52. Dr Mary Frost is Mr Banks's treating psychiatrist. She has been a medical practitioner since 1983 and a specialist psychiatrist since 1994 - exhibit W14.There is no doubt and I find that Dr Frost is an appropriately qualified and experienced expert in the field of psychiatry.

53. Dr Frost noted Mr Banks's mood in her notes and her various reports. In her report dated 16 August 2010 Dr Frost recorded "…earlier this year in the context of drinking alcohol heavily and taking Epilim **he actually made a self-harming attempt by cutting himself on the chest**…**Prior to then he was unaware of any suicidal thoughts or attempts** (my emphasis)**".** It appears that in August 2010 at least, Dr Frost was not aware of the suicide attempt involving sleeping pills and wine which occurred in 2009. Dr Frost went on in this report to note "**There was no evidence of psychosis, cognitive impairment or current suicidal ideation** (my emphasis)".

54. In her report to Dr Verrills dated 25 October 2010 Dr Frost said she remained “quite concerned about his mental state”. She said: “My sense is that he is quite profoundly depressed…”.

55. In her report dated 6 October 2011 Dr Frost repeated her understanding of Mr Banks’s relevant history, namely that he had made a self-harming attempt by cutting himself on the chest (in 2010) but that prior to that “**he was unaware of any suicidal thoughts or attempts** (my emphasis)”. She plainly was unaware at the time of this report of Mr Banks’s suicide attempt involving wine and sleeping pills, in 2009.

56. Dr Frost explained at page 6.5 in that report and observed in a number of her other reports that Mr Banks concealed his true mood behind a “stoical façade and much jolly humour, which appeared to be a way of defending himself from painful emotions”. She went on to express the opinion that “…his superficial bonhomie was somewhat of a defence against underlying despair”. She believed that even though Mr Banks did not present with depressed mood, the observation of others such as Dr Chin and particularly Mr Banks’s wife, was that he was depressed.

57. Dr Frost said at page 6.7 of this report of 6 October 2011: “I note a suicide attempt”. She had earlier in the report at page 4.5 recorded Mr Banks had made a “self-harming attempt by cutting himself on the chest” and I am satisfied this is what she was referring to at page 6.7 as a suicide attempt and that she was not aware at this time of the earlier suicide attempt in 2009.

58. In her report to Dr Chin dated 14 December 2011 Dr Frost said: “Phil continues to report difficulties in managing both his pain and mood. However, my sense is that psychologically he has actually begun an important shift into acceptance of himself as a disabled individual”.

59. Dr Frost did not see Mr Banks for nearly 9 months, from mid December 2011 until 3 September 2012. In her report of that latter date to Dr Chin she said:

> "He has cancelled a number of appointments, at times because of pain, but at times because he did not believe he needed them.
>
> "It would appear that as a result of a change of case manager with his insurance company and significant pressure on him to return to work, that his mood has deteriorated dramatically. In turn, his pain management has become out of control.
>
> "Thus, on review today Philip was quite dejected, lacking his previous sense of humour and negative in his outlook. Much of the conversation centred on his difficulties with the insurer, referral to independent specialists and battles regarding income and payment.
>
> "It would appear that as a result of these difficulties Philip began to disengage from previously enjoyed activities. This includes his historical interests, exercise and appropriate diet. I understand that since he has been in hospital there have been efforts made to try and reverse some of this deterioration."

60. In an email dated 27 September 2012 addressed to Ms Kathleen Kelly of QBE – page 146 of the Court Book - Dr Frost said of Mr Banks: "**He reports increasing feelings of hopelessness coupled with persistent neuropathic pain**, **which is starting to make him experience suicidal thoughts. He is quite a high suicide risk given his severe level of depression in association with uncontrolled pain** (my emphasis)**".**

61. In a report also dated 27 September 2012 but addressed to Dr Chin (part of exhibit W19) Dr Frost said: "Tracy (Mrs Banks) also reported that Phil (Mr Banks) has completely disengaged from pleasurable activities, which previously appeared to give him some momentary respite from pain. Instead, **he is preoccupied with how hopeless his condition is, how worthless he is and that everybody else would be better off without him**. **Intermittently, Phil has been confronted by quite marked severe, intrusive suicidal**

thoughts, but at present is clear he would not act on these because of his family and his faith. Nevertheless, **he remains a very high suicide risk** (my emphasis)". She raised the possibility of having Mr Banks admitted to an interstate psychiatric hospital "…**given the severity of his mood disturbance** (my emphasis)".

62. In her notes made on 15 November 2012 Dr Frost has recorded being informed, apparently for the first time, of a history from 3 years earlier (2009) of Mr Banks drunkenly killing his dog with a knife and thinking about killing himself. However in her report of the same date, 15 November 2012, to Dr Chin, Dr Frost noted a "considerable improvement" in Mr Banks's mood. She wondered if that improvement was due to Mr Banks's anticipating that he was to be given further Ketamine, which he had found of benefit for his pain.

63. In her report dated 5 December 2012 to Dr Chin, Dr Frost said that the improvement she had noted on 15 November 2012 had been sustained. However, she expressed concern that Mr Banks was engaging in self-harm because of his use of a stretcher to distort his earlobe. She found this behaviour reminiscent of his cutting his chest (in 2010).

Major Depressive Disorder

64. Dr Frost first diagnosed Major Depressive Disorder in her report dated 6 October 2011 – part of exhibit W15. She diagnosed a Major Depressive Episode at pages 6.9 and 7.1 but she then noted at page 7.5 the beliefs of a treating psychologist (Dr Isherwood-Hicks) and a treating psychiatrist (herself) that Mr Banks's impairment "…is unlikely to change substantially with or without medical treatment in the next year". Taking this into account, she went on at page 7.7 to diagnose "Major Depressive Disorder with atypical features".

65. Dr Frost did not mention any formal psychiatric diagnosis in any of her subsequent reports tendered at the hearing. She gave live evidence at the hearing in which she confirmed her diagnosis of Major Depressive Disorder in these terms: "In my report (6 October 2011) I called it an episode. I suspect now which is almost 18 months since that report was written but my sense is that Mr Banks is quite recurrently depressed or quite chronically depressed so it's moved probably more from an episode to a disorder but I can stand by that at the time of the report in that sense" – transcript page 207.9.

66. I take this to mean that Dr Frost diagnosed Mr Banks as suffering a Major Depressive Disorder persisting at the time she gave her evidence on 25 February 2013, and that she stood by the validity of that diagnosis when she had previously made it concerning Mr Banks in her report of 6 October 2011.

67. Dr Frost said she could diagnose Major Depressive Disorder in the absence of a subjective complaint of depressed mood, provided that a second symptom of that loss of interest is displayed by the individual. It was her opinion that "at the time (6 October 2011) **and since** (my emphasis) that he has sufficient associated symptomatology despite his "nack of obverting" (*sic* – this is plainly a transcription error – I believe the correct words were "lack of reporting") a complaint of depression when I first saw him. Subsequently Mr Banks has started to speak more openly about depression but I would – his wife's observation to be, if you go to the criteria you'll – DSM IV which I don't actually have in front of me, there is a qualification as observed by others, and so I've used his wife's observation to support what was my clinical awareness but I needed verification from his wife…" – transcript 205.9 to 206.1.

68. Dr Frost said that she made her diagnosis of Mr Banks both on the basis of her experience as a clinician and also in accordance with the Diagnostic and

Statistical Manual of Mental Disorders fourth edition (“DSM IV”).This is a well-known text not only to psychiatrists and psychologists but to medical practitioners generally and also to many lawyers whose work brings them into even occasional contact with mental disorders. An extract from DSM IV being the Chapter on Mood Disorders was tendered as exhibit W16.

69. In cross-examination Dr Frost agreed that DSM IV requires the finding of five or more of certain listed symptoms as being present together in the same two week period to enable a diagnosis of Major Depressive Disorder– transcript page 209.1. She said she had identified five such symptoms overall for the purpose of her report of 6 October 2011- transcript page 218.5 - including the symptom of being suicidal even though it was not present at the time of that report. She said she could include that symptom because in her view as a clinician at that time Mr Banks had exhibited recurrent thoughts of suicide – transcript page 218.5 to 218.10.

70. Dr Frost was cross-examined on the existence of any basis for her holding this view as a clinician, and on Mr Banks’s history of suicide attempts. She was unable to identify any specific history to provide that basis. At first she said she believed that she had been aware of another suicide attempt when she wrote her report of 6 October 2011. She thought it was possible there was some record of that in her notes – transcript page 219.5. Mr McConnel took her through her notes prior to 6 October 2011and it became clear that there was no such record – transcript pages 219.8 to 221.5.

71. Upon consideration of Dr Frost’s reports prior to and of 6 October 2011, her clinical notes up to that date, and of Dr Chin’s reports to Dr Frost prior to 6 October 2011, I find there is no evidence recorded that Dr Frost knew of or was told of any suicide attempt up to and at the time of her report of 6 October 2011, other than the episode when Mr Banks cut his chest. She agreed that she became aware of the suicide attempt involving alcohol in 2009 at a consultation with Mr Banks on 20 February 2013 – transcript

210.8 to 210.9. There is no written evidence before the Court that Dr Frost had become aware of that suicide attempt any earlier.

72. Notwithstanding the foregoing, Dr Frost persisted with her evidence that while Mr Banks had no suicidal ideation at the time of assessment for her report of 6 October 2011, he had had such suicidal ideation "historically" – transcript page 221.5.

73. Dr Frost gave evidence that Mr Banks had reported to her feelings of worthlessness and/or excessive or inappropriate guilt to the requisite degree for the DSM IV criteria for Major Depressive Disorder, not at the time of her assessment of him in 2011 but "during about 2010" – transcript page 222.4. She went on to clarify that Mr Banks himself did not report these feelings to her but his wife Tracy did – transcript page 222.5. I note that Dr Frost was aware from Tracy Banks of Mr Banks as a man "whose frustration and impaired tolerance of almost every aspect of his former life has led to conflict within the family" – Dr Frost's report to Dr Chin dated 25 October 2010. Dr Frost noted in that same report that Tracy Banks "confirmed my impression that he (Mr Banks) was very stoical, which masked much of his underlying fragility". It is clear and I am satisfied on the basis of this report and Dr Frost's live evidence that Dr Frost and Mrs Tracy Banks discussed Mr Banks and his symptoms as part of Dr Frost's management of Mr Banks as her patient.

74. At pages 226.6 to 227.3 of the transcript Dr Frost gave evidence of her belief that Mr Banks was suffering depression over a prolonged period even though he tried to mask those symptoms by adopting a jolly demeanour, and even though he made attempts to attend physiotherapy, hydrotherapy and to do some work. She based this conclusion on the basis that Mr Banks had been referred by other treating medical practitioners to a psychologist and then to a psychiatrist, on the reports to her from Dr Chin, on the history

provided by Mr Banks's wife Tracy from time to time, and on her (Dr Frost's) ongoing clinical assessments of Mr Banks.

75. In the transcript page 227.4 to 227.7 there is the following exchange:

> "Mr McConnell: But the point is though, isn't doctor, that in someone like Mr Banks, if you have someone who admittedly is depressed, and understandably is depressed, because of their changed circumstances and their severe pain, their constant severe pain, that nevertheless where their presentation is quite contrary to any suggestion of a marked diminished interest in activities. That that's not someone who is suffering from a major depressive episode?
>
> "Dr Frost: I still believe that I have satisfied enough of the criteria to make that diagnosis. I also cannot ignore that someone who has never previously been suicidal, makes what I believe to be a suicidal attempt. Even though, someone dismissively said "oh that's an episode of cutting". But, this is not a man who has previously cut himself".
>
> "Mr McConnel: Yes but doctor, you are not suggesting, are you, that once someone has a history of an attempted suicide, that converts their depression into a major depressive disorder?
>
> "Dr Frost: Well, clinically I am. Because that's what my training as a psychiatrist would tell me I need to do. I mean, I might be wrong, but that's where I've got to start."

76. On pages 228 to 231 of the transcript Mr McConnel asked Dr Frost questions about her observations of Mr Banks after her report of 6 October 2011, specifically arising from her reports in exhibit W19. I have identified the history of symptoms of depression and suicidal thoughts set out in those four reports under the heading "Evidence as to Mood/Suicide" earlier in these Reasons. Dr Frost took that history into account in her diagnosis of Major Depressive Disorder at the time of her live evidence.

77. Mr McConnel put to Dr Frost that the chest-cutting episode was not a suicide attempt. She remained of the opinion it was. She said: "Because he was a man with no previous psychiatric history. With no previous history of self-harm who had started to self-harm as a way of managing very painful

emotions. If somebody starts to self-harm during their teenage years, and then see me as a 30,40 year old and tells me that once again they're self-harming by cutting, I may not view that in the same way I would of somebody reporting for the first time that they were self-harming" – transcript 211.2. She was tested on this approach and justified it by saying that although such a history might prove on investigation not to have been a suicide attempt "…but for me to make that as an assumption in somebody of Mr Banks's disposition would be not appropriate clinically" – page 211.5. She went on to say "Clinically I would have to classify that as a suicide attempt until proven otherwise" - page 211.7.

78. I asked Dr Frost whether criterion number 9 under the heading "Criteria for Major Depressive Episodes" in the excerpt from DSM IV – exhibit W16 – should be read so that it could be satisfied by a single suicide attempt without recurrent suicidal ideation. She said yes, that that was her interpretation – transcript page 232.2 to 232.9.

79. Dr Frost said the DSM IV criteria permit a diagnosis of Major Depressive Disorder even in the absence of a subjective complaint of depressed mood. This can be so provided that a second symptom of that, of loss of interest, is displayed by the individual. It was Dr Frost's opinion both at the time in 2011 and since, that Mr Banks had sufficient associated symptomatology to allow her to make the diagnosis despite his not making a complaint of depression when she first saw him – transcript from 205.8. She said that in addition Mr Banks's wife had described what Dr Frost took to be signs of depression and she also took this into account in reaching her diagnosis.

80. Dr John Roberts is also a psychiatrist. He has been a medical practitioner since 1969 and a specialist psychiatrist since 1974 - exhibit E5. There is no doubt and I find that Dr Roberts is an appropriately qualified and experienced expert in the field of psychiatry.

81. Dr Roberts's evidence was his report dated 25 April 2012 – part of exhibit E6 – and his live evidence on 27 February 2013 – transcript pages 136 to 151.

82. Dr Roberts in his report did not believe Mr Banks suffered from a Major Depressive Disorder for the following reasons:

    i) in Dr Roberts's view, Mr Banks's "presentation is consistent with being depressed as a result of difficult circumstances" – page 11.5;

    ii) at his assessment by Dr Roberts Mr Banks himself identified his limitations as being related to pain – page 12.1; and

    iii) these limitations and indeed all Mr Banks's difficulties could be explained by his physical injury and his pain and, given the "paucity of symptomatology described in relation to physiological concomitants of anxiety" noted by Dr Roberts at his assessment of Mr Banks, he did not consider that a biological illness had resulted – page 12.5.

83. In his live evidence Dr Roberts identified the factors in Mr Banks's case which distinguished what Dr Roberts saw as his reactive depression from a Major depressive Disorder. These were:

    i) Mr Banks said his depression fluctuated. Dr Roberts said severe major depression is not categorised by fluctuation of moods - transcript page 138.2;

    ii) Mr Banks's superficial cheerfulness is inconsistent with major depression – page 138.7; and

    iii) engaging in fund-raising or social activities would not be consistent with a major depression – page 139.1.

84. In cross-examination Dr Roberts agreed that an essential feature of a Major Depressive Episode is either depressed mood or the loss of interest or pleasure in nearly all activities – transcript page 143.10. He agreed that the symptoms that may be characterised by that are changes in weight, changes in sleep, changes in psychomotor activity, decreased energy, feelings of worthlessness or guilt, difficulty thinking, concentrating or making

decisions, or recurrent thoughts of death or suicidal ideation, plans or attempts – transcript page 144.1 to 144.3.

85. Dr Roberts agreed that you would need all or some of the foregoing symptoms in a Major Depressive Episode to evidence a Major Depressive Disorder – page 144.4.

86. Dr Roberts agreed that Mr Banks at the time he assessed him provided a history of depression, significant weight gain, changes in sleep, and changes in memory and concentration – transcript pages 144.5 to 145.3.

87. Dr Roberts was provided with a copy of Dr Frost's report of 6 October 2011 before he assessed Mr Banks and prepared his own report. He was aware of Dr Frost's identification of a suicide attempt by Mr Banks. He did not comment on this history or on the issue of suicide or suicidal thoughts in his report or in his examination in chief. In cross-examination Dr Roberts said he would not be surprised if Mr Banks had had thoughts of suicide – transcript page 148.6.

88. He continued by saying that "you cannot infer that if a suicidal act has occurred, that a person is suffering from a major depressive illness" – page 148.10. He illustrated this point by giving examples, but these were of self-harm in prisons, or by persons suffering personality disorders and who are not suffering from depression – transcript page 149.1. These examples were clearly not relevant to Mr Banks.

89. Dr Roberts was cross-examined on some of Mr Banks's history which arose after Dr Frost's report of 6 October 2011, and after Dr Roberts's assessment of him. This was that Mr Banks was spending a lot of time in bed, that in the opinion of Dr Chin he was a very high suicide risk, that Dr Frost had reported that Mr Banks was showing increased feelings of hopelessness, coupled with persistent neuropathic pain, which was starting to make him experience suicidal thoughts. Dr Roberts agreed that each and all of these

pieces of history would be of concern to him as a clinician – transcript pages 149.6 to 150.8.

Findings

90. The Court was presented with conflicting expert opinions as to whether Mr Banks was suffering a Major Depressive Disorder. Psychiatrist Dr Mary Frost said he was whereas psychiatrist Dr John Roberts said he was not. Both experts arrived at their differing conclusions after having considered the DSM IV criteria, but also on the basis of their respective experience and expertise.

91. There is no doubt and I have already found in these Reasons that both Dr Roberts and Dr Frost are experts in the medical specialty of psychiatry.

92. Dr Roberts was engaged in this matter to provide a medico-legal opinion to the Employer (exhibit E6). He was provided with medical records and reports. He met with and examined Mr Banks on one occasion only, 22 March 2012. He has never been involved in Mr Banks's treatment.

93. Dr Frost was directly involved with Mr Banks as his treating psychiatrist for two and a half years from 16 August 2010 up to the hearing of these proceedings. Over that time she saw Mr Banks himself on 14 occasions (consultation record – exhibit W15). She met with and communicated with Mr Banks's wife Tracy alone on more than one occasion and on a number of occasions in company with Mr Banks. She provided reports to and/or communicated with other medical practitioners involved in Mr Banks's care and treatment on an ongoing basis (exhibits W15, W19 and W20).

94. On the basis of Dr Frost's overwhelming advantage over Dr Roberts when it comes to forming any clinical assessment of Mr Banks I have no hesitation in preferring Dr Frost's assessment of her patient and his symptoms over that of Dr Roberts.

95. I find that as a consequence of the injury and the physical injury Mr Banks suffered the following symptoms:

i) notwithstanding a façade of bonhomie when he presented at some psychological and psychiatric consultations, Mr Banks was suffering an underlying depressed state from about 2009 and continuing;

ii) by 6 October 2011, the date of Dr Frost's major report, Mr Banks was quite profoundly depressed;

iii) from around 2009 and continuing, Mr Banks suffered initially insomnia and subsequently hypersomnia and that he suffered these sleep disorders nearly every day;

iv) from around 2009 and continuing Mr Banks suffered fatigue or loss of energy nearly every day;

v) from around 2009 and continuing Mr Banks suffered diminished ability to think or concentrate nearly every day;

vi) from 2009 Mr Banks's weight ballooned from 92 kgs to 150 kgs and subsequently settled in the range from 120 kgs to 130 kgs;

vii) by 2010 and continuing Mr Banks was regularly suffering feelings of hopelessness and worthlessness;

viii) Mr Banks made a suicide attempt as identified by Dr Frost, namely the cutting of his chest;

ix) by September 2012 his feelings of hopelessness and worthlessness had increased and Mr Banks was experiencing marked, severe, intrusive thoughts of suicide and was a high suicide risk;

x) by September 2012 Mr Banks had completely disengaged from pleasurable activities including his hobby of painting war figurines.

DSM IV

96. DSM IV provides widely accepted criteria around which treating psychologists, psychiatrists and medical practitioners can develop their opinions and diagnoses in the light of their clinical observations so that their

peers might follow their thought processes and subject them to informed criticism.

97. In the Introduction to DSM IV there is the observation: “The specific diagnostic criteria included in the DSM IV are meant to serve as guidelines to be informed by clinical judgement and are not meant to be used in a cookbook fashion. For example, the exercise of clinical judgement may justify giving a certain diagnosis to an individual, even though the clinical presentation falls just short of meeting the full criteria for the diagnosis, so long as the symptoms that are present, are persistent and severe”.

98. In *McLean v Commonwealth* (unreported NSW Court of Appeal 31 December 1996) Santow JA considered this observation and concluded: “What is meant by a clinical presentation falling “just short” of meeting the full criteria for diagnosis is not explained in the document. The authors of the text do acknowledge, however, by that statement, that there must be some flexibility in the application of the criteria for particular witnesses”.

99. This of course must be correct. DSM IV and its successor DSM V and similar works are text books. They represent distillations of psychiatric and psychological expertise and consensus and are of great value in the diagnosis and treatment of mental disorders. This does not mean that such texts including DSM IV are holy writ to be applied rigidly to each and every case. It does not even mean that there is some quantified permissible degree of divergence from the criteria set out in the text, but no more. If that were so then there would be scant room for the operation and application of hard-earned and invaluable clinical psychiatric/psychological expertise on a case by case basis.

100. Expert opinion must have a demonstrated basis to be accepted by a Court. A well-known statement of the law is that by Heydon JA in *Makita (Australia) Pty Ltd v Sprowles* (2001) 52 NSWLR 705 at paragraph [85] as follows:

> In short, if evidence tendered as expert opinion evidence is to be admissible, it must be agreed or demonstrated that there is a field of "specialised knowledge"; there must be an identified aspect of that field in which the witness demonstrates that by reason of specified training, study or experience, the witness has become an expert; the opinion proffered must be "wholly or substantially based on the witness's expert knowledge"; so far as the opinion is based on facts "observed" by the expert, they must be identified and admissibly proved by the expert, and so far as the opinion is based on "assumed" or "accepted" facts, they must be identified and proved in some other way; it must be established that the facts on which the opinion is based form a proper foundation for it; and the opinion of an expert requires demonstration or examination of the scientific or other intellectual basis of the conclusions reached: that is, the expert's evidence must explain how the field of "specialised knowledge" in which the witness is expert by reason of "training, study or experience", and on which the opinion is "wholly or substantially based", applies to the facts assumed or observed so as to produce the opinion propounded. If all these matters are not made explicit, it is not possible to be sure whether the opinion is based wholly or substantially on the expert's specialised knowledge. If the court cannot be sure of that, the evidence is strictly speaking not admissible, and, so far it is admissible, of diminished weight.

101. I am satisfied on the balance of probabilities that Dr Frost's opinion and diagnosis concerning Mr Banks was wholly or substantially based on her expert knowledge which itself had a sufficient foundation in fact. My foregoing findings in paragraph 95 derive from evidence known to Dr Frost from her own enquiries and observations.

102. I am satisfied that Dr Frost's opinion and diagnosis accord sufficiently with the criteria in the relevant Chapter of DSM IV to provide a proper basis for her diagnosis of Major Depressive Disorder in the context of her clinical knowledge and observations of Mr Banks.

103. I find that Mr Banks suffered a Major Depressive Episode on the basis of in excess of two weeks depressed mood, loss of interest or pleasure, marked changes in his weight, regular insomnia and/or hypersomnia, fatigue or loss of energy nearly every day, diminished ability to think or concentrate,

feelings of hopelessness and worthlessness, and a suicide attempt being his cutting of his chest.

104. I find that as at 6 October 2011 and as at the hearing of this matter the Worker Phillip Banks was suffering a Major Depressive Disorder on the basis of the persistence and in some areas worsening of these symptoms.

Causation

105. Even though the Employer raised the issue of causation in its pleading, it did not run the hearing on the basis of any alternative cause of any Major Depressive Disorder, other than the injury and the physical injury and their consequences. No evidence emerged in the course of the hearing of any potential alternative cause. The Employer by its counsel in final written submissions made no submission on the issue of causation.

106. Both parties ran the hearing on the basis that Mr Banks has suffered and is continuing to suffer depression as a consequence of his severe neuropathic pain. They disagreed about the diagnosis to be made in the context of this depression but not about the cause of the depression.

107. I am satisfied on the evidence before me on the balance of probabilities and I find that Mr Banks's mental injury arose as a consequence of the injury and the physical injury. I find that the severe neuropathic pain experienced by Mr Banks over the years from 2008 directly and materially contributed to the development and persistence of the Major Depressive Disorder – see per Southwood J in *Keith Van Dongen v Northern Territory of Australia* [2009] NTSC 1 at paragraph [39].

Conclusion and Orders

108. I declare that the Worker Phillip Banks suffered a Major Depressive Disorder as a consequence of the injury and the physical injury.

109. I will hear the parties as to costs.

Dated this 11th day of November 2014

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John Neill
STIPENDIARY MAGISTRATE