[2015] AATA 336

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| Division | **GENERAL ADMINISTRATIVE DIVISION** |
| File Number | 2014/2831 |
| Re | Robert PAYNE |
|  | APPLICANT |
| And | Secretary, Department of Social Services |
|  | RESPONDENT |

# Decision

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| Tribunal | **Mr C Ermert, Member** |
| Date | **18 May 2015** |
| Place | **Melbourne** |

The Tribunal affirms the reviewable decision.

..........................[sgd].............................

**Mr C Ermert**

**SOCIAL SECURITY** - disability support pension – whether the Applicant’s impairment attracts 20 points

**Legislation**

*Administrative Appeals Tribunal Act 1975* (Cth)

*Social Security Act 1991* (Cth)

*Social Security (Administration) Act 1999* (Cth)

**Secondary Materials**

Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011

# REASONS FOR DECISION

**Mr C Ermert**

**18 May 2015**

# introduction

1. On 29 November 2013 Mr Payne, the Applicant, advised Centrelink of his intention to lodge a claim for Disability Support Pension (DSP). Centrelink is the service provider for the Department of Social Services, the Respondent. In his application for DSP Mr Payne listed the following disabilities:

* spine degeneration;
* right knee injury;
* depression;
* sleep apnoea; and
* nerve pain.

1. On 28 January 2014 a Centrelink officer rejected the claim. Mr Payne sought a review of this decision. On 26 March 2014 an Authorised Review Officer (ARO) of Centrelink affirmed the decision to reject the claim.
2. Mr Payne sought a review of the ARO decision by the Social Security Appeals Tribunal (SSAT). On 7 May 2014 the SSAT affirmed the decision.
3. This matter is an application for review of the SSAT decision.

# the hearing

1. Ms Nivedana Achuthan of Victoria Legal Aid represented Mr Payne. Mr Payne gave evidence by telephone under affirmation. For Mr Payne I heard by telephone the evidence of Ms Urszula Wynd, employment consultant, and Dr Paul Martin, his treating general practitioner (GP).
2. Mr Andrew Shelley of Sparke Helmore Lawyers represented the Respondent. For the Respondent I heard by telephone the evidence of Dr Christopher Minogue, a medical advisor to the Centrelink Health Professional Advisory Unit.
3. I had before me the documents provided by the Respondent in accordance with section 37 of the *Administrative Appeals Tribunal Act 1975* (the T-documents). I took into evidence the Applicant’s Statement of Facts, Issues and Contentions dated 13 February 2015 with 10 Attachments, with the date of Attachment 4, Report of HPAU, amended to 15 January 2015. In addition, for Mr Payne I took into evidence:

* Exhibit A1 - a copy of a Centrelink Form *Information about participation in a program of support* in respect to Mr Payne dated 9 April 2015; and
* Exhibit A2 – copies of three job advertisements dated 7, 8 and 14 April 2015.

1. I also took in the Respondent’s Statement of Facts and Contentions dated 26 February 2015 with one Attachment, the Job Capacity Assessment Report dated 5 August 2014.

# legislation

1. The legislation relevant to this matter is contained in the *Social Security Act 1991* (the Act).
2. Section 94 of the Act relevantly prescribes the qualifications for DSP:
3. A person is qualified for disability support pension if:
   1. the person has a physical, intellectual or psychiatric impairment; and
   2. the person’s impairment is of 20 points or more under the Impairment Tables; and
   3. one of the following applies:
      1. the person has a continuing inability to work;
4. A person’s impairment is assessed by reference to the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011* (the Impairment Tables).

# qualification period

1. Sections 41 and 42 and Schedule 2 of the *Social Security (Administration) Act 1999* (the Administration Act) provide that the date for the determination of the claim is the date of the claim. The only exception is where a person is not qualified on the date of claim but becomes qualified within 13 weeks of lodging the claim, in which case their start day is the day they become qualified.
2. In this case the qualification period is from 29 November 2013 to 28 February 2014.

# issues

1. The issues are whether, during the qualification period, Mr Payne:

* had any physical, intellectual or psychiatric impairments; and, if so
* the impairments attracted a rating of 20 points or more under the Impairment Tables; and, if so
* he had a continuing ability to work.

# evidence

## Mr Payne

1. In his examination-in-chief Mr Payne said that he was not academically inclined at school but was good at woodwork and metalwork. He became a plumber but had to stop this work in 2009 as a result of his disabilities.
2. Mr Payne said that his neck problems date from the 1990s. He first consulted a GP about his neck in 1996. He stated that he was seen by an orthopaedic specialist at Nambour Hospital. In September or October 2009 he was examined by a surgeon who told him that he had nerve compression in his neck but that surgery was not indicated as it was too risky. Mr Payne described the pain from his neck as severe and causing headaches and pain in his right arm. Treatment by a chiropractor gave him some relief but the pain was not well managed.
3. Mr Payne said that in 2012 he was referred to a neck specialist in Brisbane and was put on a waiting list. When he moved to Victoria he went to a GP in Geelong, Dr Paul Martin. He said Dr Martin advised him to take himself off the waiting list as it was a *waste of time*.
4. Mr Payne said his neck condition affected his ability to work as a plumber as he could not reach forward, look down or do repetitive work. He said his neck caused him pain when he was installing solar systems in 2012 and reached forward over caravan roofs. He said his neck also impacted on his work as a salesman as it involved reaching forward, looking down, and loading and unloading goods from vehicles and shelves.
5. In regard to his lower back condition Mr Payne said it first caused hip problems in about 1986 when he was aged 23. He said he had chiropractic, acupuncture, massage and physiotherapy treatment. He saw a specialist when he was about 30 years old. He said the specialist he saw in 2009 for his neck also examined his lower back and believed surgery could be performed.
6. Mr Payne said his lower back condition prevents him from sitting or standing for any length of time, that he has difficulty kneeling, squatting and bending over and that he cannot lift weights greater than about one kilogram. He said that reaching overhead causes him a sharp pain. He can move his neck in all directions only with difficulty and he cannot look over his shoulder. He said it was possible but difficult for him to bend and pick up a coffee cup at knee height. He has to use the arms of a chair to get up from the chair. Mr Payne said he also has difficulty using his right hand to lift milk or handle coins. He said he can sit in or drive a car for 30 minutes.
7. In regard to his mental health Mr Payne said he was first diagnosed with depression in 2002. He was first prescribed medication in 2009 and he has seen counsellors a few times. He said he suffered very serious depression in 2009 which included thoughts of self-harm. He saw a doctor in Nambour who referred him to Dr Christopher Martin, a consultant psychiatrist. He said Dr Martin recommended he continue with the counselling and the daily medication of 20mg of citalopram.
8. Mr Payne said that after about 18 months he stopped taking the medication. He said that his symptoms returned after three months and his doctor prescribed Cipramil. He said Dr Paul Martin later increased the daily dosage from 20 to 30mg.
9. Mr Payne described the impact his depression had on his work capacity as having trouble getting out of bed to go to work and an inability to face people. He said he had difficulty in dealing with customers and he found his boss very aggravating.
10. Mr Payne said Dr Paul Martin referred him to Mr Noel Weaver, a psychologist, who helped him a lot. Mr Payne said that around October and November 2013 he was still a bit depressed. He was feeling better after seeing Mr Weaver and stopped drinking alcohol for five months. He said that since then stress has affected him and he has started drinking again. He said he also had a few sessions with a clinical psychologist, Mr Brett Jones.
11. In regard to the impact of his mental condition Mr Payne said that:

* he hardly ever went out socially or went to clubs;
* he did not read newspapers or books as he lost concentration after five or ten minutes;
* he has a lot of difficulty with self-care and his wife has a lot of trouble in understanding his issues; and
* it takes him 24 hours to make decisions.

1. Mr Payne said his depression impacts on his ability to work and undertake training as a result of his loss of concentration and his inability to talk to other people.
2. In regard to his knee condition Mr Payne said that he had a work accident in 2007 as a result of which he had the cartilage removed. He said the problems still exist and he had difficulty squatting and kneeling and he has a numb spot in his knee. He does not use a walking stick but is considering doing so. He can stand for five to 10 minutes before he suffers pain in his knee.
3. Ms Achuthan referred to the Job Capacity Assessment (JCA) Report of December 2013 (T-documents pages 129-134), which recorded Mr Payne as saying he could stand for 60 minutes. Mr Payne said this was incorrect. He had told the assessor that it took him 60 minutes to walk a distance of two kilometres. Mr Payne said there had been no improvement in his knee since 2012.
4. In regard to the amount of walking he undertakes, Mr Payne said he has pain in his knee most of the time but he keeps walking to *push through the pain*. He said he also takes Panadol before going for a walk. When climbing stairs he has to use the handrail as he cannot put weight on his right knee.
5. Ms Achuthan asked Mr Payne about his ability to undertake various types of work. His responses were:

* truck driving − this involves a lot of double de-clutching and sitting for long periods, neither of which he can do;
* computing and occupational health and safety – this involves the use of computers and requires study which he cannot do as he was never academic;
* solar system sales – dealing with customers is too difficult for him;
* retail or customer service work – he cannot do such work as he struggles to do any work for one hour a day;
* part-time hardware sales – he tried such work but it involved stocking shelves and loading and unloading trucks and he was in pain all the time;
* the jobs advertised in Exhibit A2 (sales assistant paper and hardware, retail sales assistant for Clark Rubber, and hardware retail assistant) – all require heavy lifting, loading, unloading and stocking shelves, which he cannot do.

1. When Mr Payne was asked about his experience with employment agencies, he said he would show them his medical scans and tell them what he could not do. He said they were not able to find any suitable positions for him.
2. In regard to his neck condition, Mr Shelley asked if Mr Payne had seen any specialists other than the surgeon he consulted in 2009. Mr Payne said he saw another orthopaedic surgeon in Noosa in 2010 and also a neurosurgeon in Brisbane but agreed that the visits were for medico-legal reasons, not for treatment. Mr Payne agreed that he was referred to an orthopaedic specialist at Royal Brisbane and Women’s Hospital and then The Prince Charles Hospital at Chermside but his turn on the waiting list never came. Mr Payne said he did not have the reports from the surgeon he saw in 2009 and he did not know where that surgeon might be now.
3. In regard to his lower back condition Mr Payne agreed with Mr Shelley that:

* the condition pre-dated his neck condition;
* he saw a specialist in the 1990s;
* he consulted the orthopaedic surgeon in 2009; and
* he saw other specialists only for medico-legal reasons.

1. In regard to the effects of his lower back condition, Mr Payne said he suffers pain from his neck through his shoulder blade to his thoracic spine when he tries to reach over his head.
2. In regard to the effects of his knee condition Mr Payne said he tries to walk every day. On a good day he can walk a distance of six kilometres. On a bad day he can walk only two kilometres. He said he takes pain killers but his knee still swells up, and he has to stop quite often. He tries to walk through the pain. He suffers pain when climbing stairs and can stand for only five minutes until the pain gets really bad.
3. In regard to his psychiatric condition Mr Payne said he saw counsellors in 2009 and has been taking Cipramil. He said he took himself off Cipramil in 2012 but his condition started to deteriorate after two months. He saw Mr Weaver five times, up until December 2013. Mr Weaver retired and recommended him to Mr Brett Jones, whom he saw after about seven months. He said the delay was because Medicare only pays for five treatments a year.
4. In re-examination Mr Payne said:

* if he bends forward or lifts his arms he gets pain right through his shoulders to his thoracic spine;
* he continues to take Cipramil and has not been off this medication since 2012; and
* he attends Dr Paul Martin, his GP, for counselling.

## Ms Wynd

1. Ms Wynd confirmed that she is an employment consultant and that she wrote the letter dated 26 August 2014 appended to the Applicant’s Statement of Facts, Issues and Contentions as Attachment 3. She explained that the phrase *suitable and sustainable employment* meant employment that does not impact on Mr Payne’s conditions and that he can sustain for a period of time.
2. Ms Wynd said she looked for employment for Mr Payne in fields outside his background. She expressed the following opinions in regard to the employment options she considered in Mr Payne’s case:

* training for and employment in Occupational Health and Safety – the training course was of 12 months’ duration and would require reading, writing and sitting which would not help Mr Payne’s problems. In addition, Mr Payne lacked the necessary concentration and motivation, and with his depression he was unlikely to be successful in his studies. As a result she did not consider this training and employment to be suitable for Mr Payne;
* driving school buses – the job required other duties including cleaning the buses. Also, the driving function required double de-clutching which would aggravate Mr Payne’s lower back. Ms Wynd did not support this as suitable employment;
* water meter reading – the work required a lot of bending down, writing and getting in and out of a car. Ms Wynd did not consider this to be suitable employment for Mr Payne;
* working as a sales assistant, as suggested in the JCA Reports – this work requires long periods of standing. Ms Wynd did not investigate this type of employment.

1. Ms Wynd opined that Mr Payne is not capable of working 15 hours per week. She said it would be better for Mr Payne to work two to four hours a day, to a maximum of eight hours per week.
2. Under cross-examination Mr Shelley directed Ms Wynd to her letter, in which she wrote:

I believe Robert has been prevented from improving his capacity to find, gain or remain in employment for a minimum of 15 hours per week as a result of his impairments… [A]pproving a Disability Support Pension…would allow Robert improved financial assistance to manage his chronic pain, mental health issues and provide the timeframe that he needs to address any possibility of sustainable training and/or employment goals.

Mr Shelley asked if Mr Payne could increase his work capacity to 10 or 12 hours a week. Ms Wynd said it was her belief that Mr Payne’s conditions were degenerative but with the right conditions it would be possible for him to improve his capacity.

## Dr Paul Martin

1. Dr Martin said that during the period September 2013 to December 2014 he had seen Mr Payne as a patient for about 15 consultations lasting 15 to 30 minutes each. Ms Achuthan referred him to his letter dated 18 November 2013 (T-documents page 95) and asked about his statement that *there is no planned surgical intervention* in regard to Mr Payne’s spinal condition*.* Dr Martin opined that surgical intervention was indicated only for severe unrelenting pain and that studies show no difference between surgery and conservative management for Mr Payne’s conditions.
2. Dr Martin said he was aware that Mr Payne’s GP in Queensland had put him on a waiting list to see a specialist surgeon. Dr Martin said he placed Mr Payne on a waiting list at Geelong Hospital because he was aware that Centrelink required a surgical review before the condition could be considered to be fully treated. He noted that Mr Payne was added to the waiting list in June 2014 but still had not been seen.
3. Ms Achuthan referred Dr Martin to Dr Minogue’s report of 15 January 2015 (Applicant’s Statement of Facts, Issues and Contentions, Attachment 4) in which he stated that reasonable treatment for radiculopathy *could include intraforaminal corticosteroid injections(s).* Dr Martin responded that while injections reduce swelling, they make no difference to the condition and provide no lasting benefit.
4. In answer to questions from Ms Achuthan, Dr Martin said that Mr Payne had received all reasonable treatment for his cervical and lumbar spine conditions.
5. Referring to Mr Payne’s mental health, Ms Achuthan asked Dr Martin why he reported Mr Payne’s depression as generally well-managed with minimal or limited impact on his ability to function (T-documents page 116). Dr Martin said depression did not constitute a major impairment on Mr Payne’s day-to-day functioning.
6. Ms Achuthan took Dr Martin to Mr Weaver’s report dated 11 December 2013 (T-documents pages 118-128). Dr Martin said he made the referral to Mr Jones at Mr Payne’s request, to help manage some of his habits. Dr Martin did not agree with Mr Weaver’s assessment that the impact of Mr Payne’s depression would persist for 13 to 24 months. Dr Martin said the condition was longstanding and would not resolve in under 24 months.
7. When asked why he had referred Mr Payne to Mr Jones in July 2014, Dr Martin said that Mr Payne’s mental condition had deteriorated, his alcohol consumption had gone up and a second alternative psychological opinion might be needed. Dr Martin agreed with Mr Jones’ assessment that the impact of Mr Payne’s mental condition was expected to last for more than 24 months (Applicant’s Statement of Facts, Issues and Contentions Attachment 5).
8. Dr Martin confirmed that his opinion that Mr Payne’s mental condition attracted five impairment points (Attachment 1 of the Applicant’s Statement of Facts, Issues and Contentions) related to the qualification period.
9. In regard to Mr Payne’s work capacity Dr Martin said that his assessment that Mr Payne’s work capacity was not greater than eight hours per week (T-documents page 95) and that he would be *unable [to work] for at least 15 hours within the next two years* were based on Mr Payne’s clinical presentation, his difficulties with sitting, concentration, walking, standing and looking down. Dr Martin opined that Mr Payne cannot work or train. He said his opinions applied to both manual and non-manual work.
10. Referring to Dr Minogue’s opinion that Mr Payne could work as a part-time hardware sales assistant (Attachment 4 of the Applicant’s Statement of Facts, Issues and Contentions) Dr Martin said this work would require training, stacking and lifting goods and looking up, so Mr Payne could not do it.
11. With respect to Dr Minogue’s view that Mr Payne *probably formed the view…that he would be better off on DSP”*, Dr Martin said the comment disregards the fact that Mr Payne cannot do much at all. Dr Martin said it was not a reasonable conclusion to draw.
12. Under cross-examination Dr Martin said he had not seen any reports as a result of Mr Payne’s referrals to orthopaedic surgeons in 2009, 2010 and 2011.
13. Mr Shelley took Dr Martin to the descriptor for 10 points in Impairment Table 4 − Spinal Function. Dr Martin confirmed his assessment that Mr Payne was unable to sustain overhead activities, as provided in (1) (a) of the Table and had difficulty moving his head in all directions (1)(b) as a result of his cervical spine condition. Dr Martin said he had not noted an inability to bend forward to pick up an object from knee height (1)(c) or a need for assistance to get out of a chair (1)(d).
14. Referring to the section for five points in Impairment Table 5 − Mental Health Function Dr Martin gave the following responses:

* (1)(a) self care – there was an impact;
* (1)(b) social/recreational activities – there was an impact;
* (1)(c) interpersonal relationships – definitely;
* (1)(d) concentration – yes;
* (1)(e) behaviour – no; and
* (1)(f) work/training – yes.

1. Mr Shelley referred Dr Martin to his report of 5 May 2014 (Attachment 2 of the Applicant’s Statement of Facts, Issues and Contentions), in which he wrote *as a consequence of the above conditions and given respect to his education and previous training…he is not capable of working more than 15 hours per week.* Dr Martin said the paragraph was *miss-written* and that Mr Payne’s education and previous training had no impact on his work capability.

## Dr Minogue

1. Mr Shelley referred Dr Minogue to his report dated 15 January 2015 (Attachment 4 of the Applicant’s Statement of Facts, Issues and Contentions). Dr Minogue confirmed that the opinions regarding the spinal conditions and radiculopathy he recorded on page seven of his report relate to Mr Payne’s cervical spine. He said he was not asked to report on the lumbar spine.
2. Dr Minogue considered this condition to be amenable to further treatment and said Mr Payne’s work capacity could improve with further treatment of his arm. He said his opinion of Mr Payne’s work capacity being at least 15 hours per week applied to non-manual work.
3. Under cross-examination Dr Minogue agreed that he had not seen Mr Payne, nor did he speak to Dr Martin. Ms Achuthan directed Dr Minogue to page seven of his report where he stated [I]t *is reasonable in my opinion for the longstanding spinal conditions to be considered FDTS with an impairment rating of 10 points.* Dr Minogue said that this was his opinion at the time. However, on reflection, as Mr Payne has not seen a neurosurgeon and his radiculopathy might improve with further treatment, Dr Minogue considered that the radiculopathy was not fully diagnosed, treated and stabilised.
4. Ms Achuthan referred to the report of Dr Martin dated 9 July 2014 (Attachment 1 of the Applicant’s Statement of Facts, Issues and Contentions), in which he wrote:

Surgical intervention for both cervical and lumbar spinal conditions is recognized as being reserved for very specific ongoing symptoms. They are, intractable pain consistent with radiculopathy and supported by imaging, objective neurological loss of function of power and to a lesser extent sensation. Mild loss of sensation without intractable pain is generally managed conservatively particularly when multiple levels of degeneration are present.

Dr Minogue said he did not agree and that radiculopathy may be quite treatable surgically.

1. Ms Achuthan put to Dr Minogue Dr Martin’s opinions that surgery is not recommended and therefore not a reasonable treatment, and that cortisone treatments provide only temporary relief. Dr Minogue did not agree and said that cortisone treatments can result in long term improvement in some cases.
2. Ms Achuthan told Dr Minogue that the SSAT found that the cervical spine condition was fully diagnosed, treated and stabilised. Dr Minogue did not agree, saying that the standard approach to radiculopathy was referral to a neurosurgeon.
3. Ms Achuthan asked Dr Minogue about the basis of his statement that

[a]n overall impression gained from review of the very numerous documents is that Mr Payne probably formed the view in 2012, when he was no longer able to cope with manual aspects of solar systems installation, that he would be better off on DSP.

Dr Minogue said there were some inconsistencies in the history of the levels of Mr Payne’s disability and that in his experience some people were reluctant to seek alternative work.

1. Ms Achuthan recounted Mr Payne’s evidence that he had also had difficulties with the non-manual aspects of work. Dr Minogue said he did not recall any mention of non-manual work. Dr Minogue agreed that Mr Payne’s mental health could be a long term condition with fluctuating effects on his capacity for work. Dr Minogue did not agree with Dr Ahmed’s assessment that Mr Payne was capable of only zero to seven hours work per week and that his mental condition was unlikely to improve.
2. Ms Achuthan referred Dr Minogue to his opinion that *resumption of suitable work would probably be of substantial benefit to his mental health status, control of alcohol/other substance use and overall well-being.* Dr Minogue responded that the health benefits of work are well recognised and Mr Payne might benefit if he were encouraged to consider alternative work. Dr Minogue said there were indications of a reluctance to consider other employment.
3. Dr Minogue said he did not find the opinions of Ms Wynd and Dr Martin in regard to the limitations on Mr Payne’s employment compelling. Ms Achuthan directed Dr Minogue to the job advertisements in Exhibit A2 and put to him that the jobs were all unsuitable as they required manual handling, bending forward and concentration. Dr Minogue did not agree, saying that larger employers had flexible working arrangements.
4. Ms Achuthan referred Dr Minogue to Dr Martin’s evidence that Mr Payne’s mental condition, his poor concentration and poor planning capability were problems with regard to employment. Dr Minogue replied that if Mr Payne’s radiculopathy was a cause of his poor concentration then it was treatable. He added that if Mr Payne found suitable employment his mood might improve, with a beneficial effect on his work.

# tribunal consideration

1. It is accepted by both parties, and I find from the evidence, that during the qualifying period Mr Payne had impairments from the following conditions:

* lumbar spine degeneration;
* cervical spine degeneration;
* right knee injury; and
* depression.

1. As a result I find that Mr Payne satisfies section 94(1)(a) of the Act.
2. I must now determine whether Mr Payne’s impairments attract an Impairment Rating of 20 points or more under the Impairment Tables (section 94(1)(b)).
3. Section 6(3) of the Impairment Tables provides that an impairment rating can only be assigned if the person’s condition is *permanent* and the impairment is likely to persist for more than two years. Section 6(4) provides that a condition is *permanent* if the condition has been fully diagnosed by an appropriately qualified medical practitioner, and has been fully treated and stabilised.
4. Section 6(5) of the Impairment Tables states that for a condition to be fully diagnosed and treated by an appropriately qualified medical practitioner the following is to be considered:

(a) whether there is corroborating evidence of the condition; and(b) what treatment or rehabilitation has occurred in relation to the condition;

and(c) whether treatment is continuing or is planned in the next 2 years.

1. I will consider each condition in turn.

## Lumbar Spine Degeneration

1. Ms Achuthan contends that this condition is fully treated, diagnosed and stabilised. She contends that Mr Payne has received all reasonable treatment and relies on the opinion of Dr Martin that surgical intervention is not indicated in Mr Payne’s case.
2. Mr Shelley contends that this condition is not fully diagnosed as Mr Payne has not been examined by a neurosurgeon. Mr Shelley submits further that Dr Martin reported on only the cervical condition, not the lumbar condition.
3. Mr Payne gave evidence of seeing a neurosurgeon in 2009. However, he has no report from that visit. Since then he has been on waiting lists to see a neurosurgeon in Brisbane and Geelong, without success. I am satisfied from the evidence that, in relation to the condition at the time of the qualification period, Mr Payne has not been examined by a neurosurgeon.
4. Dr Martin opines that surgical intervention is indicated only for severe unrelenting pain and that studies show no difference between surgery and conservative management for Mr Payne’s conditions. Therefore, Dr Martin considered that Mr Payne had undergone all reasonable treatment for his spinal conditions.
5. Dr Minogue did not agree with Dr Martin and said that radiculopathy may be quite treatable surgically. He said also that referral to a neurosurgeon is standard practice for these conditions.
6. I have before me the conflicting evidence from two doctors, neither of whom is a specialist in the area of spinal conditions. Before reaching the conclusion that Mr Payne’s spinal conditions are fully diagnosed I would require an opinion from an appropriately qualified medical practitioner, in this case a neurosurgeon. I find now that Mr Payne’s lumbar spinal degeneration is not fully diagnosed. Accordingly, this condition cannot be considered *permanent* in the terms of section 6(4) of the Impairment Tables. As a result I cannot assign an Impairment Rating to this condition.

## Cervical Spine Degeneration

1. As with Mr Payne’s lumbar spine condition I have the conflicting opinions of Dr Martin and Dr Minogue, but no evidence from a neurosurgeon. I therefore find that Mr Payne’s cervical spinal degeneration is not fully diagnosed. Accordingly, this condition cannot be considered *permanent* in the terms of sub-section 6(4) of the Impairment Tables. As a result I cannot assign an Impairment Rating to this condition.

## Right Knee Injury

1. Ms Achuthan contends that this condition is fully diagnosed, treated and stabilised. In support of this claim she refers to:

* the report of Dr Dierich dated 25 March 2008 (T-documents pages 43-47) in which he records *permanent mild to moderate pain in the right knee*;
* the report of Dr Ahmed dated 13 November 2012 (T-documents pages 57-64) in which he records *“Right knee pain…pain in the right knee; worse on standing, squatting, kneeling”*; and
* the JCA Report dated 6 October 2009 (T-documents pages 21-26) recording *“Lower Limb Deficiencies…Permanent…Fully diagnosed treated and stabilised”*.

1. In the Respondent’s Statement of Facts and Contentions Mr Shelley states that *[t]he applicant’s right knee condition is fully diagnosed, treated and stabilised*.
2. There is no evidence of this condition requiring further diagnosis or treatment. I accept that the reports of Dr Dierich (T-documents pages 43-47) and Dr Ahmed (T-documents pages 57-64) provide sufficient diagnosis of the condition and its treatment. I accept also the assessment of the JCA officer that the condition is fully diagnosed, treated and stabilised. I find that the condition is fully diagnosed, treated and stabilised. Accordingly, this condition can be considered for an Impairment Rating assignment.
3. In his evidence Mr Payne said he does not use a walking stick. He can stand for five to ten minutes before he suffers pain in his knee. He tries to walk every day. On a good day he can walk a distance of six kilometres. On a bad day he can walk only two kilometres. He said he takes pain killers but his knee still swells up, and he has to stop quite often. He tries to walk through the pain. He suffers pain when climbing stairs and can stand for only five minutes until the pain gets really bad.
4. Both Ms Achuthan and Mr Shelley contended that Mr Payne’s impairment from his right knee was mild and therefore attracted a rating of five points.
5. The descriptors in Impairment Table 3 − Lower Limb Function for a rating of five points are, relevantly, that a person has some difficulty climbing stairs and that he or she is unable to stand for more than 10 minutes or needs to use a walking stick.
6. Mr Payne’s evidence is that he does not yet need to use a walking stick. However, he was clear in his evidence that he cannot stand for more than 10 minutes.
7. Importantly in this case, the introduction to Impairment Table 3 states that self-reporting of symptoms alone is insufficient. There must be corroborating evidence of the person’s impairment, for example, from the person’s treating doctor, medical specialist or physiotherapist or rehabilitation therapist.
8. In this case corroborating evidence is found in:

* the JCA Report dated 17 August 2012 (T-documents page 49) recording that Mr Payne stated that he is *limited to… standing for 15 min…*;
* the JCA Report dated 23 November 2012 (T-documents page 67), noting that Mr Payne said he is *limited to…standing for 15 min*;
* the JCA Report dated 18 December 2013 (T-documents page 131) recording that *was able to ambulate the stairs in the office slowly, [and that] he stated he can stand for up to an hour*; and
* the JCA Report dated 5 August 2014 (Attachment to Respondent’s Statement of Facts and Contentions) stating *he was able to ambulate the stairs in the office slowly at the time of the last assessment, he now reports that due to the cold weather he is unable to do this, he stated that he can stand for 20 minutes, previously reported a standing tolerance or 1 hr during his last assessment…There is a mild functional impact on activities using lower limbs. Robert has some difficulty climbing stairs*.

1. In his evidence Mr Payne contested the JCA officer’s record of their conversation with regard to his reported ability to stand for one hour. He said that the one hour related to the time it took him to walk two kilometres. I accept Mr Payne’s account in that regard. One hour is clearly at variance with the other descriptors of his standing impairment.
2. However, there is no corroboration of Mr Payne’s evidence that he is unable to stand for 10 minutes. Without corroboration I am prevented from accepting the evidence of Mr Payne. Accordingly, I have no evidence that satisfies the requirement for five Impairment Points. As a result I find that Mr Payne’s knee condition attracts a rating of zero points.

## Depression

1. Mr Shelley contends that at the time of the qualification period Mr Payne’s depression was not fully treated or stabilised. Mr Shelley referred to the report of Mr Weaver dated 11 December 2013 (T-documents pages 118-128) in which Mr Weaver recommended further treatment. Mr Shelley submitted that Mr Payne did not seek further treatment until June 2014 when he started seeing Mr Jones.
2. Ms Achuthan contends that this condition is longstanding, having arisen in 2005. Ms Achuthan submits that Mr Payne’s depression was confirmed by Dr Christopher Martin, psychiatrist, in 2010, and that the diagnosis was endorsed by the subsequent assessment of Mr Jones. She submits that before, during and after the qualification period Mr Payne has had consistent treatment with counselling and medication, apart from a six month break in 2009. She contends that the condition was fully diagnosed, treated and stabilised during the relevant qualification period and that it therefore attracts an Impairment Rating of at least five points under Impairment Table 5.
3. I note the following evidence:

* the report of Dr Christopher Martin dated 5 March 2010 (Attachment 8 of Applicant’s Statement of Facts, Issues and Contentions) in which he wrote :

Robert described a past psychiatric history of depression in 2001…and the depression resolved without specific antidepressant therapy.

…Things have not been too bad since, but over the last year or so there have been a number of stressors…Robert recalled that you had started him on citalopram 20mgs daily in early December…he has had a very pleasing response to this medication. His anxiety and dysphoria have dampened, his thinking is clearer and his executive dysfunction improved

…He has been seeing psychologist Sue Walters every couple of weeks for some months now and has found this intervention to be very helpful

…I think he is now in good remission from his major depressive episode. I would suggest that he continue his psychological sessions to work on various life issues which he is facing and to continue with citalopram for the next twelve months

* the report of Mr Noel Weaver, , dated 11 December 2013 (T-docs pages 118-128), recording:

(Diagnosis) Persistent Depressive Disorder (Dysthymia)…(Treatment) 5 sessions of counselling and treatment for depressed mood…(Future/planned treatment) Further counselling from another psychologist (due to my retirement) …Referral to CRS for further assessment… (The impact of this condition on the patient’s ability to function is expected to persist for) 13-24 months.

* the report of Mr Brett Jones dated 3 July 2014 (Attachment 5 of the Applicant’s Statement of Facts, Issues and Contentions), recording :

(Diagnosis) Major Depressive Disorder…(Future/planned treatment) It is my intention to continue to see Robert for the foreseeable future based on CBT/Schema and mindfulness…(The impact of this condition on the patient’s ability to function is expected to persist for) more than 24 months…Robert has had psycho-pharmacological treatment since 2009 and psychological counselling since 2010 and symptoms still persist with little change.

* the report of Dr Paul Martin dated 5 May 2014 (Attachment 2 of the Applicant’s Statement of Facts, Issues and Contentions) in which he recorded:

With regard to depression the patient has suffered from this condition since approximately 2009…He has attended additional counselling more recently without improvement by way of reduced medication or outcome measures…I believe his condition is stable with appropriate medication level and no response to further interventions.

1. I consider that Dr Paul Martin’s report correctly reflects the diagnosis and treatment of the condition by appropriately qualified medical practitioners. I accept that the lack of improvement in outcomes reflects that the condition is stabilised. I accept that the condition was fully diagnosed, treated and stabilised during the qualification period and I find accordingly. I find further that the condition can be assessed for an Impairment Rating.
2. The introduction to Impairment Table 5 states, relevantly, that self-report of symptoms alone is insufficient. There must be corroborating evidence of the person’s impairment.
3. I accept as appropriate corroborating evidence the report of Dr Martin dated 1 September 2014 (Attachment 1 of the Applicant’s Statement of Facts, Issues and Contentions) in which he wrote::

I consider that he lives independently but may sometimes neglect self-care and grooming

…He has reduced capacity to actively involve in recreational activities but this may be a reflection of his spinal condition.

He has interpersonal relationships that are strained including tension and arguments...

He has reduced concentration beyond 30 minutes…

He does not undergo work or training, however I would expect that he would have difficulties in these areas if he did undertake them.

His tolerance levels appear to be reduced

…

I would therefore consider the patient’s condition would be consistent with attracting 5 points rather than zero.

1. I accept that this evidence satisfies the requirements of the descriptors in Table 5 for the assignment of five points and I find accordingly.

## Total Impairment Rating

1. In my findings I have assigned ratings to Mr Payne’s conditions as follows:

* lumbar spine degeneration – no rating assigned;
* cervical spine degeneration – no rating assigned;
* right knee injury – zero points; and
* depression – five points.

1. The combined impairment rating for Mr Payne’s conditions is five points.

# conclusion

1. The total impairment rating is five points. This is less than the 20 points required to satisfy section 94(1)(b) of the Act. In order to satisfy section 94(1) of the Act, all the sub-sections must be satisfied. Mr Payne does not satisfy the requirements of section 94(1)(b) of the Act. As a result he cannot satisfy all the provisions of section 94(1) of the Act and there is no need for me to consider the other sub-sections of section 94(1).
2. The result is that during the qualification period Mr Payne was not qualified for DSP. I find accordingly.
3. This finding relates to Mr Payne’s condition at 28 February 2014. If Mr Payne feels that his conditions have changed since that time he is at liberty to submit a fresh application for DSP.

# decision

1. I affirm the reviewable decision.

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| I certify that the preceding 104 (one hundred and four) paragraphs are a true copy of the reasons for the decision herein of Mr C Ermert |

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Dated 18 May 2015

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| --- | --- |
| Date of hearing | **20 April 2015** |
| Advocate for the Applicant | **Nivedana Achuthan - Victoria Legal Aid** |
| Advocate for the Respondent | **Andrew Shelley - Sparke Helmore** |