Camilleri and Repatriation Commission (Veterans’ entitlements) [2015] AATA 822 (26 October 2015)

|  |  |
| --- | --- |
| Division | **VETERANS' APPEALS DIVISION** |
| File Number | 2014/5435 |
| Re | Paul Camilleri |
|  | APPLICANT |
| And | Repatriation Commission |
|  | RESPONDENT |

# Decision

|  |  |
| --- | --- |
| Tribunal | **Senior Member A C Cotter** |
| Date | **26 October 2015** |
| Place | **Brisbane** |

The decision under review is affirmed.

..................................[Sgd]......................................

**Senior Member A C Cotter**

**CATCHWORDS**

VETERANS’ AFFAIRS – disability pension – operational service – depressive disorder – alcohol abuse – whether defence caused – causal connection required – whether Depressive Disorder SoP upholds contention – “persistent pain” relevant factor – evidence to the contrary – medical reports suggest pain not interfering with work or leisure activities – Depressive Disorder SoP not satisfied – whether Alcohol Abuse SoP upholds contention – whether clinically significant psychiatric condition at relevant time – requirement not met – not service related and not defence-caused – decision under review affirmed.

**LEGISLATION**

Veterans’ Entitlements Act 1986 (Cth), ss 70(5), 120(4), 120B(3),196B(3)

**CASES**

Roncevich v Repatriation Commission (2005) 222 CLR 115

Repatriation Commission v Gorton (2001) 65 ALD 609

**SECONDARY MATERIALS**

Statement of Principles concerning Depressive Disorder (Instrument No. 84 of 2015)

Statement of Principles concerning Depressive Disorder (Instrument No. 28 of 2008)

Statement of Principles concerning Alcohol Dependence and Alcohol Abuse (Instrument No. 2 of 2009)

# REASONS FOR DECISION

**Senior Member A C Cotter**

**26 October 2015**

# INTroduction

1. Mr Paul Camilleri served in the Australian Army from 6 August 1974 to 12 December 1994. He rendered eligible defence service for the whole of that period.
2. In July 2012, Mr Camilleri lodged a claim for disability pension for depressive disorder and alcohol abuse, neither of which had previously been accepted as service related. In his application form, it was stated that the depressive illness was the result of chronic pain that he had experienced for a long time, and that the alcohol abuse was associated with that depressive illness and chronic pain.[[1]](#footnote-1)
3. On 18 June 2013, the Commission decided that the depressive disorder and alcohol abuse were not related to service.[[2]](#footnote-2) The Veterans’ Review Board subsequently affirmed that decision.[[3]](#footnote-3) Dissatisfied with that decision, Mr Camilleri seeks a review of that decision by this Tribunal.
4. Before dealing with the issues raised in this matter, it is convenient to outline the key legislative provisions which are relevant to my determination.

# The legislative framework

1. Section 70 of the *Veterans’ Entitlements Act 1986* (Cth) (“Act”) deals with, amongst other things, the eligibility for pensions where a member of the Forces is incapacitated from a defence-caused injury or defence-caused disease. In particular, s 70(5) relevantly provides that an injury suffered by a member of the Forces shall be taken to be a defence-caused injury, or a disease contracted by such a member shall be taken to be a defence-caused disease if:
2. the … injury or disease, as the case may be, arose out of, or was attributable to, any defence service … of the member; …
3. In *Roncevich v Repatriation Commission*, the majority of the High Court observed that this subsection required a causal, and not merely temporal, connection between the claimed injury or disease and the defence service.[[4]](#footnote-4) They went on to say that the provision manifested a legislative intention to give “defence-caused” a broad meaning:

 … and certainly one not necessarily to be circumscribed by considerations such as whether the relevant act of the appellant was one that he was obliged to do as a soldier. A causal link alone or a causal connection is capable of satisfying a test of attributability without any qualifications conveyed by such terms as sole, dominant, direct or proximate.[[5]](#footnote-5)

1. In determining whether the claimed injury or disease is defence-caused, the Commission is required to decide the matter to its “reasonable satisfaction”.[[6]](#footnote-6)
2. Section 120B(3) of the Act relevantly provides that in determining a claim, the Commission is to be reasonably satisfied that an injury suffered or disease contracted by a person was defence-caused only if:
	1. the material before it raises a connection between the injury or disease of the person and some particular service rendered by them; and
	2. there is in force a relevant Statement of Principles made under the Act*[[7]](#footnote-7)* that upholds the contention that the injury or disease is, on the balance of probabilities, connected with that service.

# issues for the tribunal

1. The issues which fall for me to determine are:
	1. whether Mr Camilleri’s claimed depressive disorder is defence-caused; and
	2. whether Mr Camilleri’s claimed alcohol abuse is defence-caused.
2. In deciding those issues, I will need to consider the *Statement of Principles concerning Depressive Disorder* (Instrument No. 84 of 2015) (“Depressive Disorder SoP”) and the *Statement of Principles concerning Alcohol Dependence and Alcohol Abuse* (Instrument No. 2 of 2009) (“Alcohol Abuse SoP”), which are the relevant Statements of Principles in force at the time of this decision. As it is open to Mr Camilleri to rely on the Statement of Principles which preceded the Depressive Disorder SoP and which was in force at the time of the Commission’s decision,[[8]](#footnote-8) I will also refer to it (Instrument No. 28 of 2008).

# consideration

1. I deal below with the two conditions claimed by Mr Camilleri, namely Depressive Disorder and Alcohol Dependence, by reference to the matters required to be considered under s 120B(3).

## Depressive Disorder

### Connection between the injury/disease and service?

1. Mr Camilleri’s previously accepted condition are:
	1. rupture medial meniscus and anterior cruciate ligament, left knee;
	2. lumbar spondylosis; and
	3. osteoarthritis of the left knee.[[9]](#footnote-9)

There was a considerable amount of medical evidence produced to the Tribunal which verified those conditions.

1. In his statement lodged in these proceedings, Mr Camilleri gave a history of his knee and back complaints.[[10]](#footnote-10)
2. He first suffered an injury to his left knee in 1978 in an Australian Rules football game during a sports afternoon at Wacol in Brisbane, where he was then based. His statement records his leg getting worse over time from physical training, exercises and battle efficient tests, and his regular work. He started to experience his knee locking on different occasions and suffer chronic pain to the leg. Initially, he was treated with physiotherapy and Panadeine Forte, before having an X-ray in November 1980. That led to him having an arthroscopy in February 1981, followed by surgery in April 1981. Over the ensuing years, he continued to experience problems and pain with his knee, having a number operations before undergoing a total knee replacement a few months before the hearing.[[11]](#footnote-11)
3. In 1989, Mr Camilleri first experienced pain to his lower back when he dismounted his truck incorrectly. He first attributed this to his bending down and loading and unloading stores over time, but was subsequently referred to a specialist after he continued to experience back pain. He was told to do swimming and to have physiotherapy. While consulting a specialist about the constant pain in his left leg which was becoming “unbearable”, he also saw another specialist for his chronic back pain which he had been experiencing more frequently. A CT scan revealed that he had major back problems that needed fixing before his knee operation. He therefore underwent a spinal fusion operation in 1993. Following that surgery, he was diagnosed with 20% loss of use of his back.[[12]](#footnote-12)
4. Throughout these periods, Mr Camilleri said that he started to feel depressed, because of the chronic pain he experienced and the effect it was having on him. He said that he failed a Sergeant’s course twice as he was unable to concentrate due to his injuries, and that depressed him further. He self-medicated using alcohol.[[13]](#footnote-13)
5. Mr Camilleri started seeing his general practitioner, Dr Sushil Kramer, in 1998 for his chronic back and knee pains.[[14]](#footnote-14) In June 2012, she referred him to a psychiatrist, Dr Ivan Holm, for treatment for depression.
6. Dr Holm first saw Mr Camilleri in June 2012. In his first report of 28 November 2012, he confirmed his diagnosis that Mr Camilleri suffers from both Dysthymic Disorder and Alcohol Abuse, and both conditions related to service.[[15]](#footnote-15) His report of 31 July 2013 noted:

Mr Camilleri has undoubtedly had significant and chronic pain from around 1992 when he under went [sic] spinal surgery and then in 1993 when he had a knee reconstruction.

In relation to the onset of his depression however it is very difficult to pinpoint. While undoubtedly he reports depressive symptoms on and off for many years it would appear that his depressive symptoms have been noticeably worse over the past two years in conjunction with worsening pain and it is over this period of time that I consider that he has been suffering from a diagnosable depressive illness notably Dysthymic Disorder. The argument would therefore be that Mr Camilleri was suffering from chronic pain of significantly more than six months duration at the time of the clinical onset of his depressive Disorder.[[16]](#footnote-16)

1. There is no doubt that Mr Camilleri suffered knee and back injuries and that they were attributable to his service. He says that, over an extended period of time, he has suffered chronic pain from both conditions. Given those matters, and in light of Dr Holm’s diagnosis and opinion, I am satisfied that the material before me raises a connection between the diagnosed disease, Dysthymic Disorder, and Mr Camilleri’s service.
2. The question then arises as to whether the Depressive Disorder SoP upholds that contention.

## *Does the Statement of Principles uphold the contention?*

1. As mentioned earlier, the Depressive Disorder SoP is the relevant Statement of Principles in force at the time of this decision. It concerns depressive disorders which includes “persistent depressive disorder (which includes the condition previously known as dysthymia)”.[[17]](#footnote-17) Persistent depressive disorder is said to mean[[18]](#footnote-18) a disorder of mental health meeting certain listed diagnostic criteria derived from DSM-5.[[19]](#footnote-19) They include: depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least two years; and presence, while depressed, of two or more of a number of specified states or symptoms, which include low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness.
2. Section 9 of the Depressive Disorder SoP states that at least one of the specified factors must exist before it can be said that, on the balance of probabilities, depressive disorder is connected with circumstances of a person’s relevant service. For persistent depressive disorder, the factor in s 9(1)(k) is relevant here:
	1. having persistent pain of at least six months duration at the time of the clinical onset of depressive disorder;

In a similar vein, the factor in s 9(15) is also relevant:

(15) having persistent pain of at least six months duration at the time of the clinical worsening of depressive disorder;

1. Persistent pain is defined to mean:
2. continuous;
3. almost continuous; or
4. frequent, severe, intermittent pain;

which may or may not be ameliorated by analgesic medication and is of a level to cause interference with usual work or leisure activities or activities of daily living.[[20]](#footnote-20)

1. Section 10(1) emphasises that the existence in a person of any factor in s 9 must be related to the relevant service rendered by that person.
2. As mentioned earlier, Dr Holm diagnosed Mr Camilleri as suffering from Dysthymic Disorder. That diagnosis was originally made using the diagnostic criteria derived from DSM-IV,[[21]](#footnote-21) but he confirmed the diagnosis of chronic depressive disorder under DSM-5.[[22]](#footnote-22) In particular, he confirmed that Mr Camilleri had depressive symptoms over at least two years with worsening pain. During cross-examination, he said that, while Mr Camilleri was depressed, he would have experienced at least three of the symptoms specified in paragraph (b) of the definition, namely insomnia or hypersomnia, low self-esteem and feelings of hopelessness.[[23]](#footnote-23)
3. Although he was questioned during cross-examination on his observations and the basis for his opinion, there was no attempt to directly challenge Dr Holm’s diagnosis, or put forward a contradictory opinion.
4. Based on Dr Holm’s reports and evidence at the hearing, I am satisfied that Mr Camilleri suffers from what is known as persistent depressive disorder under the Depressive Disorder SoP.
5. The question therefore arises as to whether Mr Camilleri had “persistent pain” (as defined) of at least six months’ duration, either at the time of clinical onset of the depressive disorder (factor 9(1)(k)) or at the time of clinical worsening of the depressive disorder (factor 9(15)).
6. The definition of “persistent pain” is important, as it involves, not just a consideration of the degree or level of pain and its frequency, but also the interference with the person’s usual work or leisure activities or the activities of daily living.
7. The Advocate for Mr Camilleri referred me to a number of documents in the material before the Tribunal, which she contended demonstrated the SoP requirements being met.[[24]](#footnote-24) From my reading of them, they fell into several broad categories. It is convenient to deal with them in that fashion.
8. First, there were a number of medical reports and records from Mr Camilleri’s treating doctors, Dr Holm (whose evidence I deal with later), Mr Camilleri’s general practitioner, Dr Kramer, and his Orthopaedic Surgeon, Dr Peter McMeniman. Dr Kramer’s report[[25]](#footnote-25) was too general to be of any assistance, it simply stating that Mr Camilleri “suffers from chronic back pains and left leg and knee pains”. In any event, that letter appears to relate to the condition as at the date of the letter, which was well after the depressive disorder was diagnosed by Dr Holm and well after what he determined as its clinical onset or clinical worsening. Nor does the letter address the impact of the pain on Mr Camilleri’s work, leisure or daily activities. The notes from Dr Kramer’s clinic were referred to as a bundle, but I was not referred to anything specific in them. Dr McMeniman’s letter of 11 July 2013[[26]](#footnote-26) states that Mr Camilleri continued to experience ongoing symptoms in his knee despite surgical treatment and a rehabilitation program. For that reason, he thought Mr Camilleri should reduce his working hours to 4.5 hours per day, five days a week. Again, that relates to a period after Dr Holm had already diagnosed the disorder and well after what he determined was its clinical onset or clinical worsening. I therefore do not think it advances the present considerations. This group of documents also included a report of Dr Andrew Strokon,[[27]](#footnote-27) confirming that Mr Camilleri had knee surgery in 1994 (which is not controversial) and a minute from Dr B Grehan,[[28]](#footnote-28) Compensation Medical Advisor with the Department of Veterans’ Affairs, which related to the question of whether the definition of chronic pain was met in this case.
9. The next group of documents to which I was referred related to medical or workers’ compensation certificates[[29]](#footnote-29) and a letter from Mr Camilleri’s employer[[30]](#footnote-30) concerning his reduction in hours following his knee surgery in May 2012. Again, that material relates to circumstances after Dr Holm had already diagnosed the disorder and after what he considered as clinical onset or clinical worsening.
10. A number of medical attendance and treatment reports prepared during Mr Camilleri’s period of service were also referred to. They classified him as being fit for restricted duties for periods ranging from one week to two months (following his spinal surgery).[[31]](#footnote-31) There is no suggestion in that material that Mr Camilleri suffered persistent pain which interfered with his usual work or leisure activities for a period of at least six months.
11. Finally, there is a group of documents[[32]](#footnote-32) relating to restrictions that were placed on Mr Camilleri’s duties. They were expressed as “no long standing or marching; no heavy lifting; PT own pace - with special attention ext (1) exercise, back”. That in turn led to the recommendation (and approval) of a medical waiver so that he could be “suitably employed in his current ECN within the limits of his restrictions”.[[33]](#footnote-33) Notwithstanding those restrictions, it appears that Mr Camilleri continued to perform his job satisfactorily and that his usual work activities were not interfered with. His annual report for the period contained comments from the Assessing Officer and the Commanding Officer such as:

BDR Camilleri has performed well during his posting 7 FD Bty. He is assessed as being average in his peer group.[[34]](#footnote-34)

Bdr Camilleri has performed to a high standard and I have been quite satisfied with his work.[[35]](#footnote-35)

1. In his evidence at the hearing, Dr Holm initially sought to draw a connection between Mr Camilleri’s depressed mood and his failure to progress in his career. In particular, he recalled Mr Camilleri describing the difficulties he experienced in his service, including failing a Sergeant’s course on more than one occasion. Mr Camilleri told Dr Holm about his difficulties meeting the physical requirements because of his injuries and feeling despondent about his prospects of advancement. He was concerned that his service career would be cut short or restricted. Dr Holm said that he suspected that Mr Camilleri was suffering from depression at the time of his course failures; Mr Camilleri told him that he struggled with the academic side of the course, with poor memory and concentration.[[36]](#footnote-36)
2. When it was put to Dr Holm during cross-examination that the failed courses were not in 1993 and 1994 (as he had been led to believe), but a decade earlier, in 1983 and 1984, he conceded that those events were so long ago that he did not think one could confirm or deny a diagnosis of depression based only on having difficulty with the course. He also conceded that comments recorded in Mr Camilleri’s records at the time suggested that he may not have had the aptitude to take on the required tasks.[[37]](#footnote-37) When told of the further comments after the failed second course in 1984, Dr Holm acknowledged that the more likely explanation for the failure was that Mr Camilleri did not have the ability to take on, or learn, the required tasks to be an NCO.[[38]](#footnote-38) He also agreed with the Commission’s Advocate that comments put to him concerning Mr Camilleri’s performance in his storeman’s role, just prior to his discharge, suggested that he was coping with that position.[[39]](#footnote-39)
3. Further, under questioning from the Commission’s Advocate, Dr Holm did not express any definitive opinion as to the clinical worsening of Mr Camilleri’s depressive disorder; all he could say was that when he saw Mr Camilleri in 2012, he suspected that he had experienced “not just onset but probably a clinical worsening of a condition which may well have been present for longer”.[[40]](#footnote-40)
4. For the Commission, it was contended that Mr Camilleri’s service records failed to disclose an interference with work or leisure activities from chronic pain during his service. After his discharge, Mr Camilleri continued to work as a storeman until 2012.[[41]](#footnote-41)
5. The Advocate for the Commission referred me to a number of documents on Mr Camilleri’s personnel records. In particular, the annual reports over a number of years were very complimentary of him. For example, the 1983 report described him as a good storeman who contributed to the efficient running of the store. The 1984 report stated that he was

 … a strong loyal NCO who is very efficient in his duties as a Bdr storeman. His excellent knowledge of Q accounting enables him to produce work of a high standard.

He was described as “an asset to the unit” who performed well above the standard required of his rank.[[42]](#footnote-42) Significantly, those reports coincide with the periods during which Mr Camilleri unsuccessfully attempted the Sergeant’s course.

1. Similarly, favourable comments are to be found in a number of other reports to which I was referred. In particular, it appears that Mr Camilleri also took on a number of extra-curricular roles, such as the administration manager of the Battery’s, Regiment’s and Brigade’s rugby teams (1984), and the President of the ORs club and a member of the Regiment’s Funds Committee.[[43]](#footnote-43) In early 1987, Mr Camilleri gained a B pass grade in a course, Storeman Technical General (Adv), and was recommended for employment as a Storeman Technical General (Advanced).[[44]](#footnote-44) The 1988 report recommended further training and promotion to Tech Sergeant.[[45]](#footnote-45)
2. Not long before his discharge and after his back and knee surgery in 1993 and 1994 respectively, Mr Camilleri’s performance was described by the Assessing Officer, Major G.K. Phillips, as follows:

BDR Camilleri is a mature and competent NCO who has made a significant contribution to the effectiveness of this unit in the ‘Q’ area. His knowledge of his trade is without equal amongst his peers …

A good performance from a soldier who has made a good contribution.

In concurring with that assessment, the Commanding Officer, Lieutenant Colonel M.J. Fitzgerald, remarked that Mr Camilleri was a conscientious NCO who had “performed to a high standard during the reporting period” and made a “significant contribution to the effectiveness of the unit”.[[46]](#footnote-46) Elsewhere in the same report Mr Camilleri was described as being “competitive with his peers”.[[47]](#footnote-47)

1. The Commission’s Advocate also referred me to a number of medical assessments contained in Mr Camilleri’s files, which he said indicated Mr Camilleri had an acceptable fitness assessment over the period of service. They can be summarised as follows:
2. In a Medical Board Examination Record of 7 July 1983, Mr Camilleri’s fitness was assessed as FE (Fitness Everywhere).[[48]](#footnote-48)
3. A report of Dr Bernard Bloch of 18 August 1987 assessed Mr Camilleri as fit for full duties and leisure activities other than weight lifting.[[49]](#footnote-49)
4. In his report of 8 June 1988, Dr P Giblin expressed the opinion that Mr Camilleri would remain “fit for current duties for the next three to five years, but thereafter, degenerative changes will cause more symptoms”.[[50]](#footnote-50)
5. A medical assessment of 30 March 1989 noted Mr Camilleri: “Running own pace. Non wt bearing exercise preferred.”[[51]](#footnote-51)
6. In a Patient Referral and Report dated 5 October 1989, Jane Morrissey reported that Mr Camilleri was feeling much better on coming to physiotherapy, with only slight pain on full extension. Mobilisation was considered unnecessary as “he had a mobile pain free lumbar spine”.[[52]](#footnote-52)
7. The medical waiver dated 17 October 1991 noted that Mr Camilleri could be suitably employed in his current ECN within the limits of his restrictions.[[53]](#footnote-53)
8. A report of Dr J Bentivoglio dated 14 March 1994 noted that 12 months after his back operation, Mr Camilleri experienced only “occasional symptoms”.[[54]](#footnote-54)

Apart from referring me to the documents I have referred to previously, Mr Camilleri’s Advocate did not seek to challenge or question these matters.

1. Having considered the material referred to me, I am not satisfied that the factor in s 9(1)(k) is made out. In particular, I am not satisfied that there is sufficient evidence that Mr Camilleri suffered continuous, or almost continuous, or frequent, severe intermittent pain to such a level that it caused interference with his usual work or leisure activities or his activities of daily life for any extended period during his service. Indeed, there is reasonable evidence to the contrary. The medical reports and assessments referred to in the preceding paragraph suggest no such interference. The annual performance reports relating to Mr Camilleri raise a strong inference that, no matter what pain (if any) he was experiencing, it was not interfering with his ability to do his job. In fact, he was assuming an added responsibility, undertaking voluntary roles and successfully undertaking courses beyond his normal workload.
2. Nor am I satisfied that the factor in s 9(15) is made out. Again, there is a lack of evidence of Mr Camilleri experiencing pain to such a level as to cause interference with his usual work or leisure activities for any extended period. While there is evidence of Mr Camilleri reducing his hours some time after his operation in 2012 and after he first consulted Dr Holm, there is no evidence of any substantial interference with his activities before that time. When questioned by the Commission’s Advocate about time that he had off work due to his pain, Mr Camilleri was only able to point to one doctor’s certificate, for a period from 8 to 9 August 2011.[[55]](#footnote-55)
3. As I do not consider that Mr Camilleri satisfies the Depressive Disorder SoP, it is open for his claim to be considered under the SoP that was in force at the time of the Commission’s decision. While that SoP referred to chronic pain rather than persistent pain, and the definition was slightly different, it contains the same relevant requirement as the current definition, namely that the level of pain is such as to cause interference with usual work or leisure activities or activities of daily living. As that was central to my reasoning under the current Depressive Disorder SoP, I do not think the previous SoP is any more favourable to Mr Camilleri.

## Alcohol Abuse

### Connection between the disease and service?

1. Mr Camilleri first started to drink alcohol in 1974. He says his consumption was not excessive and would describe himself as a moderate drinker who drank most days. He believes that his alcohol abuse is all related to his defence service, in that he had to attend mess and unit functions. As a live-in member with nothing else to do, and not wanting to be left out, he tended to drink. With the stress of work, he increased his consumption in about 1984 to a six pack a day to a bottle of rum. In about 1994, his consumption increased to about half a carton a day to a bottle of bourbon. He attributed that to his depressive disorder. Because of his chronic pain and depressive disorder, he increased his consumption to two bottles of bourbon a week in 2013.[[56]](#footnote-56)
2. Dr Holm estimated that Mr Camilleri would drink at least five and possibly up to 10 standard drinks per day; he was unable to control his drinking despite his awareness that it was endangering his health.[[57]](#footnote-57)
3. Based on his consultation with Mr Camilleri, Dr Holm diagnosed him as suffering from Alcohol Abuse. He noted that had caused interpersonal and social difficulties, including significant effects on Mr Camilleri’s relationship with his wife due to his irritability. He observed that Mr Camilleri’s alcohol abuse had worsened in the preceding two years and that was associated with his depression.
4. Based on Mr Camilleri’s evidence and Dr Holm’s assessment and diagnosis, I am satisfied that the material raises a connection between Mr Camilleri’s alcohol abuse and his service.

## *Does the Statement of Principles uphold the contention?*

1. As mentioned earlier, the applicable Statement of Principles is No. 2 of 2009, concerning both alcohol dependence and alcohol abuse. Relevantly, the latter is defined to mean a psychiatric condition that meets the listed diagnostic criteria (derived from DSM-IV-TR), being a maladaptive pattern of alcohol use leading to clinically significant impairment or distress as manifested by one or more listed symptoms occurring within a 12 month period. Relevantly, one of the listed symptoms is continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol (such as arguments with spouse about consequences of intoxication, physical fights).[[58]](#footnote-58)
2. Based on Mr Camilleri’s evidence and Dr Holm’s diagnosis, I am satisfied that Mr Camilleri suffers from alcohol abuse as defined.
3. Section 5 of the Statement of Principles provides that at least one of the factors set out in s 6 must be related to the person’s relevant service. Section 6 then goes on to provide that the factor must exist before it can be said that, on the balance of probabilities, alcohol abuse is connected with the person’s relevant service. Section 8 states that if a relevant factor in the SoP includes an injury or disease in respect of which there is a SoP, then the factors in that last mentioned SoP apply in accordance with the terms of that SoP as in force from time to time.
4. Relevantly, s 6(a) provides the following factor:
	1. having a clinically significant psychiatric condition at the time of the clinical onset of alcohol dependence or alcohol abuse;

Also relevant in the present case is the factor in s 6(f), which reads:

* 1. having a clinically significant psychiatric condition at the time of the clinical worsening of alcohol dependence or alcohol abuse;
1. The term, “a clinically significant psychiatric condition”, is defined in s 9 to mean:

any Axis I or Axis II disorder of mental health that attracts a diagnosis under DSM-IV-TR which is sufficient to warrant ongoing management, excluding alcohol-related disorders. The ongoing management may involve regular visits (for example, at least monthly), to a psychiatrist, clinical psychologist or general practitioner;

1. While Dr Holm provided a diagnosis that would fall within this description, that needs to be viewed (in accordance with s 8) in the context of the Depressive Disorder SoP, as the relevant factors include a disease which itself is the subject of a SoP. I have already concluded that, by reference to the Depressive Disorder SoP, the relevant psychiatric condition is not service related. Therefore, I do not believe that the requirements of this SoP are met, in that the relevant factors here are similarly not service related, as required by s 7. Consequently, Mr Camilleri’s contention is not upheld by the Alcohol Abuse SoP.

# CONCLUSION

1. For the reasons outlined above, I do not believe that either of Mr Camilleri’s conditions, Depressive Disorder and Alcohol Abuse, are upheld by the relevant SoPs. They are therefore not service related and not defence-caused.
2. The reviewable decision is therefore affirmed.

#

|  |
| --- |
| I certify that the preceding 57 (fifty-seven) paragraphs are a true copy of the reasons for the decision herein of Senior Member A C Cotter |

................................[Sgd]..................................

Associate

Dated 26 October 2015

|  |  |
| --- | --- |
| Date of hearing | **27 August 2015** |
| Advocate for the Applicant | **Ms H Smith, Vietnam Veterans Australia Association** |
| Advocate for the Respondent | **Mr B Williams, Department of Veterans' Affairs** |

1. Exhibit 1, T Documents, T 6, pages 15-17. [↑](#footnote-ref-1)
2. Exhibit 1, T Documents, T 17, pages 61-65. [↑](#footnote-ref-2)
3. Exhibit 1, T Documents, T 2, pages B1-B7. [↑](#footnote-ref-3)
4. (2005) 222 CLR 115, [23], per McHugh, Gummow, Callinan and Heydon JJ. [↑](#footnote-ref-4)
5. (2005) 222 CLR 115, [27], per McHugh, Gummow, Callinan and Heydon JJ. [↑](#footnote-ref-5)
6. See s 120(4) of the Act. [↑](#footnote-ref-6)
7. See s 196B(3) of the Act. [↑](#footnote-ref-7)
8. *Repatriation Commission v Gorton* (2001) 65 ALD 609. [↑](#footnote-ref-8)
9. Exhibit 1, Veteran Community Details Report printed 27 October 2014. [↑](#footnote-ref-9)
10. Exhibit 5, statement of Paul Camilleri (undated). [↑](#footnote-ref-10)
11. See Exhibit 5, statement of Paul Camilleri (undated) and Exhibit 6, AAT telephone conference February 2015. [↑](#footnote-ref-11)
12. See Exhibit 5, statement of Paul Camilleri (undated). [↑](#footnote-ref-12)
13. See Exhibit 5, statement of Paul Camilleri (undated). [↑](#footnote-ref-13)
14. Exhibit 6, report of Dr Sushil Kramer dated 16 December, 2014. [↑](#footnote-ref-14)
15. Exhibit 1, T Documents, T 7, pages 24-28. [↑](#footnote-ref-15)
16. Exhibit 1, T Documents, T 18, page 70. [↑](#footnote-ref-16)
17. Section 7(2)(a) of the Depressive Disorder SoP. [↑](#footnote-ref-17)
18. Schedule 1-Dictionary to the Depressive Disorder SoP. [↑](#footnote-ref-18)
19. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed, American Psychiatric Association, 2013). [↑](#footnote-ref-19)
20. Schedule 1-Dictionary to the Depressive Disorder SoP. [↑](#footnote-ref-20)
21. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, American Psychiatric Association, 1994). [↑](#footnote-ref-21)
22. See Exhibit 3, report of Dr Ivan Holm dated 8 April 2015. [↑](#footnote-ref-22)
23. See transcript of hearing, page 5, lines [24] to [28]. [↑](#footnote-ref-23)
24. Applicant’s closing statement, pages 3-4. [↑](#footnote-ref-24)
25. Exhibit 1, page 201, letter of Dr Sushil Kramer dated 13 March 2014. [↑](#footnote-ref-25)
26. Exhibit 1, page 87, report of Dr Peter McMeniman dated 11 July 2013. [↑](#footnote-ref-26)
27. Exhibit 1, page 120, report of Dr Andrew Strokon dated 7 June 1994. [↑](#footnote-ref-27)
28. Exhibit 1, page 73, Minute Dr B Grehan to Mr Ian Allison dated 16 September 2013. [↑](#footnote-ref-28)
29. See Exhibit 1, pages 88, 169, 174. [↑](#footnote-ref-29)
30. See Exhibit 1, page 86. [↑](#footnote-ref-30)
31. See Exhibit 1, pages 124, 136,165. [↑](#footnote-ref-31)
32. See Exhibit 2, pages 61, 62, 63, 64, 67, 69, 71. [↑](#footnote-ref-32)
33. Exhibit 2, page 65. [↑](#footnote-ref-33)
34. Exhibit 2, page 259. [↑](#footnote-ref-34)
35. Exhibit 2, page 258. [↑](#footnote-ref-35)
36. See transcript of hearing, page 5, lines [15] to [47]. [↑](#footnote-ref-36)
37. See transcript of hearing, page 7, lines [17] to [33]. [↑](#footnote-ref-37)
38. See transcript of hearing, page 7, lines [34] to [45] and page 8, lines [1] to [4]. [↑](#footnote-ref-38)
39. See transcript of hearing, page 8, lines [25] to [45] and page 9, lines [1] to [27]. [↑](#footnote-ref-39)
40. See transcript of hearing, page 11, lines [1] to [31]. [↑](#footnote-ref-40)
41. Exhibit 7, Respondent’s Statement of Facts and Contentions, paragraph [5.30]. [↑](#footnote-ref-41)
42. See Exhibit 4, attachments to letter from Respondent’s Advocate to Applicant’s Advocate dated 10 June 2015. [↑](#footnote-ref-42)
43. See Exhibit 4, attachments to letter from Respondent’s Advocate to Applicant’s Advocate dated 10 June 2015. [↑](#footnote-ref-43)
44. Exhibit 2, page 34. [↑](#footnote-ref-44)
45. See Exhibit 4, attachments to letter from Respondent’s Advocate to Applicant’s Advocate dated 10 June 2015. [↑](#footnote-ref-45)
46. Exhibit 2, page 270. [↑](#footnote-ref-46)
47. Exhibit 2, page 271. [↑](#footnote-ref-47)
48. Exhibit 6, page 27. [↑](#footnote-ref-48)
49. Exhibit 9. [↑](#footnote-ref-49)
50. Exhibit 6, page 16A. [↑](#footnote-ref-50)
51. Exhibit 6, page 33. [↑](#footnote-ref-51)
52. Exhibit 6, page 17. [↑](#footnote-ref-52)
53. Exhibit 2, page 65. [↑](#footnote-ref-53)
54. Exhibit 6, page 21e. [↑](#footnote-ref-54)
55. Exhibit 1, page 307. [↑](#footnote-ref-55)
56. See Alcohol questionnaire dated 7 January 2013, Exhibit 1, T Documents, T 10, pages 34-36. [↑](#footnote-ref-56)
57. Exhibit 1, page 25, report of Dr Ivan Holm dated 28 November 2012. [↑](#footnote-ref-57)
58. See s 3(b) of the Alcohol Abuse SoP. [↑](#footnote-ref-58)