Beasley; Secretary, Department of Social Services and (Social services second review) [2015] AATA 924 (1 December 2015)

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| Division |  GENERAL DIVISION |
| File Number(s) | 2015/1234 |
| Re | Secretary, Department of Social Services |
|  | APPLICANT |
| And | Keith Beasley |
|  | RESPONDENT |

# Decision

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| Tribunal | **Senior Member Bernard J McCabe** |
| Date | **1 December 2015** |
| Place | **Brisbane** |

The decision under review is affirmed.

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

Senior Member Bernard J McCabe

**Catchwords**

*SOCIAL SECURITY – Pensions, benefits and allowances – Disability Support Pension – 20 points or more under the Impairment Tables – Spinal injury – Whether fully treated and fully stabilised within relevant period – Relevance of pain management referral - Decision under review affirmed.*

**Legislation**

*Social Security Act 1991* (Cth)

*Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011* (Cth)

**Cases**

*Smalldon and Secretary, Department of Social Services* [2015] AATA 2

# REASONS FOR DECISION

**Senior Member Bernard J McCabe**

1. Mr Keith Beasley lodged a claim for the disability support pension (the DSP) on 18 August 2014. He suffers from a number of medical problems, the most serious of which is a spinal condition. (There is material suggesting Mr Beasley also suffers from depression, hepatitis C and hearing loss, but Mr Beasley is not relying on those conditions for the purposes of this review: see the respondent’s Statement of Facts, Issues and Contentions at [4].) The claim was rejected by Centrelink on behalf of the Secretary on the basis that Mr Beasley’s condition was not fully treated and fully stabilised because he had not attended a pain management clinic.
2. The Social Security Appeals Tribunal (the SSAT) reached a different view. It concluded Mr Beasley’s spinal condition was fully treated and stabilised and awarded 20 points under table 4 in the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011* (the Determination). The Secretary has appealed that conclusion. On 1 April 2015 this Tribunal ordered that the decision under review be stayed. If the Secretary is unsuccessful, Mr Beasley will be entitled to payment of arrears.

## How does a claimant qualify for the DSP?

1. A person claiming the DSP must satisfy a range of criteria including the so-called ‘medical criteria’ in s 94(1)(a), (b) and (c) of the *Social Security Act 1991* (Cth)(the Act). It is important to understand that I am required to make my assessment having regard to the situation when the claim was made, and in the 13 week period that followed the date of claim. That means I must consider whether the applicant was qualified for the DSP between mid-August and mid-November 2014. In making that assessment, I must not use the benefit of hindsight: I am only permitted to use the information that was known, or knowable, at the relevant time.
2. The first criterion is clearly satisfied in this case. Section 94(1)(a) says the applicant must have a physical, intellectual or psychiatric impairment. Mr Beasley’s spinal condition clearly qualifies as a physical impairment.
3. The next criterion is more contentious. Section 94(1)(b) requires that a claimant be allocated at least 20 points under one or more impairment tables. A claimant cannot be assessed against the individual impairment tables unless his condition is *permanent* – which means it is *fully diagnosed*, *fully treated* and *fully stabilised*: s 6 of the Determination. I should say at once there is no dispute that Mr Beasley’s spinal condition was *fully diagnosed* by 2013 by Dr Vogel, Mr Beasley’s general practitioner: see treating doctor’s report dated 12 August 2014 reproduced in exhibit one at pp 127-137. But the Secretary says the condition was not fully treated and fully stabilised during the relevant period because Mr Beasley had not attended a pain management clinic since. The Secretary argued a course of treatment at a pain management clinic was likely (or, more precisely, was thought likely at the time) to result in functional improvement.
4. The Secretary’s opinion was based on a report provided by Dr Adam, an occupational physician, dated 7 June 2015 (exhibit 3). Dr Adam examined Mr Beasley and reviewed his records for the purposes of these proceedings. Dr Adam concluded Mr Beasley’s spinal condition was not optimally treated, and that he could achieve significant functional improvement. He also expressed concern over the extent of Mr Beasley’s reliance on narcotic analgesics. Dr Adam said the best course of treatment would involve a “graduated programme of exercise, supplemented by appropriate use of simple analgesics” although he also noted Mr Beasley had reported he had previously tried physiotherapy without benefit. Dr Adam endorsed a recommendation that Mr Beasley be referred to a pain management clinic. He suggested a pain management clinic “would be an important component in any treatment plan for Mr Beasley.” In cross-examination, Dr Adam seemed less certain of the benefits that would flow from a course in pain management. He emphasised it made sense in the context of a graduated exercise program. He said most people experiencing pain would benefit from a pain management course, although it was unclear whether it was likely to be of significant benefit to Mr Beasley. Dr Adam suggested it was worth trying.
5. The Secretary also relied on the treating doctor’s report provided by Dr Vogel, and a report from Dr Winstanley, an orthopaedic surgeon, dated 28 November 2014: exhibit one at p 149. Dr Vogel noted Mr Beasley was referred to a pain management clinic (exhibit one at p 131). That referral does not, of itself, tell me very much. Dr Winstanley’s report was more interesting. He observed (exhibit one at p 149) Mr Beasley’s symptomatology was:

consistent with degenerative spondylosis of the lumbar spine. It is unlikely that he would be able to return to the workforce in cleaning type activity. **If his pain is persistent and requires narcotic analgesia he would benefit from review from the Pain Management Clinic at the Nambour General Hospital as to whether there is a more permanent resolution to his symptomatic state**.[Emphasis added]

1. Evidence from the pain management clinic at Nambour General Hospital confirmed Mr Beasley would be seen by that clinic within a year.
2. Dr Winstanley offered a more nuanced view in his oral evidence. He is the medical director of a rehabilitation clinic, and he is aware of the benefits of a pain management course. He saw Mr Beasley twice and examined him closely on each occasion – more closely, it turns out, than Dr Adam who agreed in cross-examination that he conducted a more limited examination on the occasion he saw Mr Beasley. Dr Winstanley said he thought Mr Beasley should attend a pain management clinic to reduce reliance on pain medication; he was not focused on the potential for improvement more generally. He said Mr Beasley’s range of movement was restricted by pain, but doubted treatment in a pain management clinic would achieve a substantial functional improvement given the underlying pathology. Dr Winstanely said Mr Beasley was optimally treated because there was no cure for what ailed him.
3. I prefer the evidence of Dr Winstanley. He is an appropriately qualified expert with experience in dealing with patients undergoing rehabilitation. He is aware of the benefits of pain management courses. He conducted a more careful examination of Mr Beasley and was able to more clearly articulate the potential benefits of a pain management clinic in Mr Beasley’s case – in particular, a reduction in the use of narcotic painkillers. He clearly explained how there was unlikely to be any substantial improvement given the underlying pathology. He acknowledged an improvement in functioning was *possible* as a result of the referral, but he was not confident of that outcome.
4. The Secretary pointed out the Tribunal had said, in *Smalldon and Secretary, Department of Social Services* [2015] AATA 2 (at [16]), it was:

not unusual for persons who have applied for DSP to be referred to pain clinics, and as a rule, it is usual for a finding that the conditions associated with that pain are not fully treated until after the pain management options have been fully explored…

1. That may be going too far. Each case turns on its own facts. In this case, I am satisfied on the evidence of Dr Winstanley in particular that the referral to the pain management clinic, while medically justified, does not suggest the underlying condition was not optimally treated. His evidence does not suggest a course in pain management “can reliably be expected to result in a substantial improvement in functional capacity”: see s 7(c) of the Determination. In the circumstances, I accept the condition was fully treated and stabilised. Impairment points can therefore be assigned.
2. How many points should be assigned? The SSAT was satisfied 20 points should be allocated given Mr Beasley’s evidence – which the SSAT found was corroborated by the evidence of Drs Vogel and Winstanley – this suggested to the SSAT he could not perform any overhead activities. Dr Adam reached a different view. He said he would assign 10 points under table 4. He reached that view after conducting his own assessment. Dr Winstanley conducted a more rigorous examination. He said Mr Beasley’s range of motion was extremely limited. At the hearing, Dr Winstanley confirmed Mr Beasley was unable to bend, move from side-to-side or lift his hands above his head. (Mr Beasley said he was *occasionally* able to get his hands above head but only with significant discomfort. He said he had taken steps to accommodate this difficulty by, for example, placing his hairdryer on a stand. He cannot do that “normally and on a repetitive basis”: s 11(3) of the Determination.) Dr Winstanley said that observation was consistent with the spinal pathology. Those observations, which I accept, suggest Mr Beasley should be allocated 20 points under table 4.
3. The third requirement in s 94(1) is set out at sub-section (c). It says the claimant must experience a continuing inability to work. There are several components to this requirement. One of the usual requirements – that the claimant actively participate in a program of support – is irrelevant in this case because Mr Beasley has 20 points allocated under the one impairment table. The Secretary contended that, even so, Mr Beasley had the ability to work more than 15 hours per week.
4. Dr Winstanley’s oral evidence in particular confirms Mr Beasley’s condition will not improve, and is likely to deteriorate. Mr Beasley’s evidence makes it clear his condition is worsening, and that he is unable to undertake many activities. He cannot work: there is no basis for concluding he could work 15 or more hours per week given his evidence and that of Dr Winstanley.

## Conclusion

1. The decision under review is affirmed. Mr Beasley is qualified to receive the DSP. The stay under s 41(2) of the *Administrative Appeals Tribunal Act 1975* is dissolved.

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| 1. I certify that the preceding 16 (sixteen) paragraphs are a true copy of the reasons for the decision herein of Senior Member Bernard J McCabe.
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Associate

Dated 1 December 2015

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| Date of hearing | **31 August 2015** |
| Advocate for the Applicant | **Ms J Forsyth** |
| Counsel for the Respondent | **Ms Blackford Slack** |