Personal Injury claims and Psychiatric Assessment (with a focus on the Victorian Wrongs Act)

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Areas of discussion

1. What is civil liability?
2. Wrongs Act.
3. Role of psychiatrists re Wrongs Act claims.
4. Impairment and thresholds.
5. Three main areas of involvement with examples.
6. Cases for discussion

A Civil Liability Claim

This is alawsuit filed by a person against another person or an organisation.
The plaintiff seeks monetary damages for injury or loss allegedly caused by the defendant.

- Types of civil claims:
  - Torts
  - Product liability
  - Business disputes (eg patent infringement).
- Psychiatrists assess Tort claims
- Australian Civil Liability Acts very similar but only NSW and Victoria have thresholds.
- Exclusions (dealt with by other legislation):
  - transport accidents
  - workers compensation claims
  - dust/tobacco-related injuries and others
- Protected events (except in specific circumstances)
  - 'good samaritans'
  - volunteers
  - food donors
- An apology/fee refund not an admission of liability

Wrongs Act 1958 (Vic) all of the below applies to this Act

- Legislation governing claims for damages for personal injury (or resulting death) in Victoria.

Duty of Care

- The legal obligation to avoid acts or omissions that could foreseeably lead to harm to another person.
- Standard of proof in a civil jurisdiction is *on the balance of probabilities*
- Breach of a duty of care usually leads to monetary compensation.
- The amount of monetary compensation depends on:
    - plaintiff's ability to earn money;
    - the extent of any personal injury;
    - the extent of any financial loss suffered;
    - the extent of any damage to personal property;
    - plaintiff's contributory negligence
    -

Standard of care for professionals

Not negligent if activity widely accepted as competent professional practice.
Peer opinion needs to be widely accepted but not necessarily universally accepted
If the court determines that wide acceptance is unreasonable, peer professional opinion is disregarded.

Non economic loss

- The Wrongs Act restricts damages for non-economic loss (e.g. pain and suffering)
- A claimant must have a "significant injury" to recover damages for non-economic loss.
- Significant injuries include :
    - loss of a breast
    - loss of a foetus
    - loss of hearing
    - impairment of 5% or more for a physical injury
    - impairment of 10% or more for a psychiatric injury
- Reaching the threshold only allows for the claim to proceed.

Damages for Mental Harm

- It has to be shown that it was foreseeable that a person of "normal fortitude" might suffer psychiatric illness if reasonable care were not taken.
- The notion of inherent involve the relatively, the "egg shell skull" rule, does not apply with regard to mental harm however this is difficult to implement in practice.

- plaintiff must have a recognised mental illness from the negligence
- a claimant with "secondary nervous shock", that is "nervous shock" arising from witnessing a traumatic incident, can only recover damages if the victim is also able to recover damages and
- in addition the plaintiff must have either witnessed the incident involving 'the victim' or have a close relationship with 'the victim'.

Pure Mental Harm and Impairment

- Psychiatric impairment can only be assessed by an approved medical practitioner (AMP) or a medical panel (the psychiatrist must have completed GEPIC training).
- Features:
  - the impairment must meet the threshold for the claim to proceed:
  - only impairment non secondary to physical injury counts (pure mental harm)
  - unrelated impairment must be discarded
  - resulting psychiatric impairment must be 10% or more for a psychiatric injury (GEPIC)
- The AMP must complete a Certificate of Assessment Sect 28LN:
    - must state if impairment reaches threshold or state that the impairment does not reach the threshold.
    - The certificate must not state the degree of impairment.
- A respondent can waive the requirement for an assessment of degree of impairment.

CERTIFICATE OF ASSESSMENT OF DEGREE OF IMPAIRMENT ARISING FROM STABILISED INJURY SECT 28LN (including explanatory notes)

- **DETAILS OF MEDICAL PRACTITIONER**
- Name : *Michael Epstein*
- Qualification : *Psychiatrist*
- **CERTIFICATION**

I certify that on 30 June 2020 I examined *Donald Trump of 1600 Pennsylvania Ave, Washington*, and I am satisfied that
The degree of impairment resulting from this person's psychiatric injury and symptoms (which has not arisen as a consequence of, or secondary to, a physical injury) is 10% or more.
Brief description of psychiatric injury assessed:
Donald Trump has a Narcissistic Personality Disorder.

- Dated: 30 June 2020
- Signed…Michael Epstein

Please note:

- This certificate must be provided by a medical practitioner who is an ***approved medical practitioner*** within the meaning of Section 28LB of the *Wrongs Act* 1958.
- This certificate must not state the specific degree of impairment.
- ***Impairment*** is defined in section 28LB of the ***Wrongs Act* 1958** to mean permanent impairment.
- **Section 28LI(1)**

(1) For the purposes of assessing the degree of psychiatric impairment the AMA Guides apply, subject to any regulations made for the purposes of this section, as if for Chapter 14 there were substituted the guidelines entitled “The Guide to the Evaluation of Psychiatric Impairment for Clinicians”.

- The degree of psychiatric impairment must not have regard to any psychiatric or psychological injury, impairment or symptoms which has arisen as a consequence of, or secondary to, a physical injury - see section 28LJ of the ***Wrongs Act* 1958.**

<u>Falls and other claims</u>

- these claims involve falls usually involving supermarkets and municipal councils.
- Some of these claimants have trivial injuries that have apparently led to profound consequences.

- The impression gained is that some have had pre-existing multiple physical and mental health issues that have been non-compensable and that the fall, if it is possibly compensable, becomes the focus of distress.
- Some seem well-versed in the criteria for PTSD but, nevertheless frequent the same location where the 'injury' occurred.
- Assessing some of these claimants is dispiriting, because credibility may be questionable.

Example - Fall in a supermarket (all examples have been de-identified)

Sharon is a 57 year old twice married woman living in an abusive defacto relationship. Both sons with drug issues - one in prison. Daughter has been diagnosed with borderline personality disorder and has had multiple psychiatric hospitalisations.

Sharon is obese and has poorly controlled diabetes mellitus Type II, hypertension, fibromyalgia, chronic fatigue and has had a variety of psychological and counselling interventions. She has been suspected of doctor shopping and of abusing prescribed medication.

She slipped on a lettuce leaf in Woolworths and claimed to be in agonizing pain. An ambulance was called and she was seen in the emergency department of a nearby hospital but had no physical injuries. Despite this she has claimed to have significant widespread pain as a result of the fall and a marked deterioration in her quality-of-life.

She has had psychiatric/psychological/physiotherapy/chiropractic/pain management and sees her GP weekly. She claims to have had no benefit from any treatment. She continues to take significant doses of opiate medication with no benefit. She has been taking prescribed opiate medication.

At interview she said "I've got PTSD" and complained of chronic pain and depression and was angry at Woolworths, her doctors and counsellors for not making her better. Despite this she continued shopping at Woolworths and it seemed to be no functional difficulties arising from her "PTSD".

Historical sexual abuse claims

These claimants are challenging to assess because of the many years that have passed since the sexual abuse occurred. Psychiatrists are provided with extensive records from the past, affidavits and other reports.
These claimants have often had a chaotic life with a dysfunctional family, other sexual and/or physical abuse, substance abuse, work and relationship difficulties and physical health problems.
These claimants often have difficulty giving a history and have particular problems with chronology. It should be noted that these claims can only be against defendants with assets such as government departments and religious bodies. Psychiatrists are asked to determine whether or not the impairment arising from the sexual abuse reaches or exceeds the threshold.
This is particularly difficult because there is often other abuse and the combination of these and the very disturbed lifestyle is difficult to tease out. We are often asked to apportion the relative contribution from different experiences of sexual abuse such as a claimant having been abused in several different children's institutions. This is not necessarily difficult but somewhat meaningless but no one else with any authority can do it. How can this be done? In general I find it useful to ask claimants which was the place that led to them having most distress and ask the same about each of the other institutions involved. One has to treat this information with a "grain of salt" because clearly any noncompensable abuse will be minimised.
These claims often require a prolonged interview and review of voluminous documentation.

Two de-identified examples

> Nick a 60 year old successful married businessmen with grandchildren described sexual abuse at a religious school when he was 14 years old. He said that a teacher, with whom he had had no previous contact, called him into his room 3 times, he briefly hugged him twice and on the third occasion sat him on his lap from which he leapt up and left the room.
>
> He had no further contact with that teacher and told no one about these incidents. He left that school at the end of the year. He became involved in same-sex activity and later became a sex worker for a group of older men who set him up in business. He married twice and had children. He has not had any psychiatric or psychological treatment or counselling.

He made a claim in the mid-1990s and received $20,000 and is now made another claim.

Frank came from a very dysfunctional family and he and his three brothers were made wards of the State when he was six years old. He was in 4 different homes and at each home claims to have suffered repeated physical and sexual abuse both by staff but also by other residents.

Since then he has had a chaotic life with drug and alcohol abuse, criminal behaviour and imprisonment. He has had multiple relationships and a number of suicide attempts. He now receives a disability support pension. He has repeated nightmares and flashbacks to the sexual assault and leads a very isolated existence.

Medical Negligence Claims

These claims are accompanied by voluminous hospital and medical records
Claimants often have a sense of grievance against hospitals and doctors.
There may be significant psychiatric impairment from medical negligence

- impairment is often a consequence of physical injury eg a botched operation
- therefore the impairment is secondary or consequential to a physical injury and does not count with regard to the impairment threshold.

This can cause concerns for AMPs, the claimant is the victim of medical negligence but for the claim may not proceed due to failure to reach the threshold for psychiatric injury.

However if there is significant physical injury then it is likely that the claim will be regarded as significant on the basis of that physical injury alone. Once the claim proceeds to a court hearing then the full range of injuries are taken into account whether or not they are secondary or consequential to physical injury.

Claims arising from medical negligence leading to death.

Assessing these claims is emotionally taxing. The assessor may have to see more than one claimant on the same day.
The assessor is usually told not to comment on liability.
The issue of secondary/non-secondary does not apply as the claimant has not suffered a physical injury.

The major issue is separating out impairment due to the death from the impairment arising from the negligence causing the death.

Liability issues with regard to Wrongs Act Claims

Psychiatrists are asked to comment on liability only with regard to medical negligence claims involving psychiatric treatment.
These include:

- inappropriate or incompetent psychiatric treatment.
- inappropriate relationships with patients.
- suicide of a psychiatric patient either as an outpatient or as an inpatient.

Claims arising from a psychiatric/psychological treatment including injury/suicide

- Was there a failure of duty of care? Was the professional activity widely accepted as competent professional practice?
- The critical issue re in-patient suicide is risk management.
    - what systems were in place for assessing risk?
    - the frequency of risk assessments.
    - actions taken as a result of changes in risk assessment.

Liability-example one (de-identified)

Marcia, a 35 year old nurse with a pethidine addiction was admitted to a psychiatric hospital by her psychiatrist. On the day of admission she stole a prescription pad, forged a prescription for 50 pethidine tablets and had the prescription filled by a nearby pharmacist, she returned to the hospital and swallowed all the tablets.

Her psychiatrist had been treating her with phenelzine (the interaction between pethidine and phenelzine was well known). The combination of pethidine and phenelzine caused malignant hypertension and a brain stem stroke. The claimant is profoundly disabled.
Seems straightforward! Clearly the hospital was liable – however

- The treating psychiatrist had prescribed phenelzine although knowing the patient was a pethidine addict.
- The treating psychiatrist had not informed the psychiatric hospital that the patient was a pethidine addict.
- The referral note only stated that the patient was very depressed.
- The treating psychiatrist claimed not to know of any interaction between phenelzine and pethidine.
- The patient had stolen the prescription pad and obtained the pethidine tablets before being admitted.
- The treating psychiatrist claimed to have no notes.

Liability-example 2 (de-identified)

- A 16 year old girl dumped by her boyfriend had overdosed and was admitted to a psychiatric hospital.
- frequent meetings with her family - she was remorseful for her overdose.
- family and staff meeting - all agreed that she had recovered and was to be discharged the next day.
- the next day she absconded and jumped in front of a train and was killed.

Disaster – the psychiatrist and hospital must be at fault! However –

- after her death a notebook was found under his mattress.
- She had written how he was fooling everyone, including her family.
- She planned her suicide and had written out her funeral requirements.
- including that his boyfriend was to read out a letter of apology and remorse at her funeral!

Treatment advice

The questions you may be asked include the following:

- Is the current treatment appropriate? If not, why not?
- What would be appropriate treatment including type and duration?
- Estimated cost:
    - Psychological treatment at varying intervals @ $260 per session
    - Psychiatric treatment @ $400 per session
    - Pain management inpatient program @ $12,000 for 8 weeks
    - Inpatient treatment@ $600-$1000 per day for 2-3 weeks depending on the program

- ◈ Medication @$100-$200 per month

The threshold regarding psychiatric injury-three cases for discussion

The three claims were challenging to assess. In particular whether or not the psychiatric impairment was secondary or consequential to a physical injury (in which case it did not count).

Case 1-The treating psychiatrist was sued (de-identified)

- ◈ Jan, a 50 year old depressed woman, psychiatric treatment for years, took Zoloft.
- ◈ She developed an intractable rash. 2 years later her Internet research showed Zoloft caused a rash. She ceased Zoloft and her rash vanished.
- ◈ Jan lost confidence in psychiatric treatment – she became too frightened to take any psychotropic medication.
- ◈ Jan's depression worsened, she attempted suicide and was hospitalized.
- ◈ She is suing her psychiatrist. Her impairment since her injury is worse by more than 10%
- ◈ Pure Mental harm or Consequential Mental Harm?

How to approach this?
The best way to approach this is to look at the alleged injury and the consequences of that injury. Is the alleged injury
secondary or consequential to a physical injury, if so, it does not count.

- ◈ **Case 2-medical negligence causing death**

- ◈ Maria, a healthy 70 year old was married to Ted for 40 years. They had travelled widely and had been successful in business together. Attended been diagnosed with multiple myeloma in 2000 to remain very well for a number of years but developed unrelated diabetes mellitus Type II leading to diabetic vascular disease, diabetic nephropathy and renal failure requiring dialysis. He had had three strokes.
- ◈ Maria was a dynamo and insisted that Ted continue to be active even if he was feeling unwell. She thought she was doing the best for him and the relationship remained very strong.
- ◈ His multiple myeloma flared up and he developed widespread bone pain and began using a walker. The injury occurred when he was entering the hospital to have dialysis. The hospital doors closed on him causing him to

fall forward and he had extensive cuts and bruises and was shaken and upset. He was taken to the emergency department where he had x-rays. Rear was reassured that although shaken he was otherwise unharmed. She was not told that there had been a small fracture of the first cervical vertebra and he proceeded to have dialysis that day.

- She continued to be very demanding of him regarding his level of activity.
- Maria was getting him ready for dialysis three days later when he collapsed and was taken to hospital and died that afternoon.
- Maria was grief stricken but are believed that she did her best.
- There was a coroners hearing and she was later told that his death was due to a "broken neck".
- Maria was mortified and came to believe that her demands on him had precipitated his death.
- She developed severe post traumatic stress disorder and depression and required psychiatric treatment.
- Is Maria's psychiatric injury due to Ted's death or to the "negligence".

How to approach this claim?
The impression gained was that she was experiencing normal grief until she was told that her husband had had a "broken neck" at which time she became severely distressed and distressed dress and has continued. She now blames herself or causing his premature death although recognising that he was terminally ill.

Case 3 -Chiropractic Injury

- Jim is a carpenter who had chronic neck pain and had chiropractic treatment weekly.
- On this occasion the chiropractor twisted his neck – Jim had immediate left sided loss of sensation and power and he was terrified he was going to die.
- He was found to have a vertebral artery dissection. He has had extensive rehabilitation but has been left with marked weakness and altered sensation. He also has nightmares and flashbacks to the incident and is severely depressed and anxious. He has been unable to return to work.
- He has a significant psychiatric impairment and has been diagnosed with post traumatic stress disorder and major depressive disorder.

Is this Pure Mental Harm or Consequential Mental Harm?

In general the close of the psychiatric injury is to the incident then the more likely it is to be pure mental harm

Summary

- Civil liability claims are complex
- Psychiatrist tasks : determine threshold, assess liability, advise on treatment.
- Significant injury required for the claim to proceed.
  - Thresholds-psychiatric injury 10% or more (non-secondary (GEPIC) WPI not required)
  - Certificate of Assessment of Degree of Impairment arising from Stabilised Injury – Sect 28LN
- Historical sexual abuse claims long ago - significant other trauma and comorbidities.
- Medical negligence claims - secondary and non-secondary impairment difficult/ liability
- Medical negligence claims leading to death/suicide – difficult to separate impairment re death and re injury.
- Falls and other claims - claimants may conflate other unrelated physical and mental health issues.
- Require comprehensive interview/good history/analysis of documents
- Concerns re equity in some claims if threshold not reached.