SAMPLE COMCARE CLAIM OPINION

This report has been de-identified extensively both with regard to names and with places

Dear Sir/Madam,

Re: Jane Doe
Date of Injury: January 2008 to November 2010
Your Reference: SDU(ANS):JFM:21105426

I saw the abovenamed on 25 June 2012 with regard to her Comcare claim. I had available copies of nine medical reports:

Your client was informed that the interview was for the purpose of a medico-legal assessment and report and confidentiality could not be guaranteed. Your client was also informed the interview was not for the purpose of providing treatment. The format of the interview was conveyed to your client who gave verbal permission for the report to be released. The information contained in this report is derived from both the interview with your client and from the accompanying documentation. The opinion expressed in this report is dependent on the accuracy of the information provided.

Jane Doe is a fifty-five year old twice divorced woman who lives with her partner in her own unit having been there since July 2011. She was allegedly injured in the course of her work as a customer service advisor with Centrelink at the Sunshine office between January 2008 and November 2010. She ceased work on 24 November 2010. A return-to-work program was prepared in late 2011 and she was assigned to return to work at the Coolaroo Centrelink office and commenced working there on 15 March 2012 working four hours per day three days per week doing receptionist work. Her hours of work increased six hours per day three days per week. As from 29 June 2012 she will also work on Fridays for another four hours per week. She has no other personal income.

She was born and raised in Melbourne, an only child to Italian parents. Her father worked as a welder and concreter and she enjoyed a close relationship with him. Her mother worked as a knitwear machinist and was also a devoted parent. Both parents were industrious and her maternal grandmother lived with the family and was a stable maternal figure in her life.

She enjoyed her schooling and wanted to become a primary school teacher but her father, having traditional values, encouraged her to leave school. She attended a Girls High School and left after completing year 11. In 1974 she commenced her employment with the Department of Social Security (Centrelink) as a typist and then 'worked her way up'.

She was brought up in a traditional Italian manner and her first marriage was arranged.

She married at the age of nineteen years. Her husband was a shoe machinist and later became an alcoholic but was not violent. Their son was born in 1979. Her husband provided little support and they separated in 1982. She left their house where her ex-husband continues to live. Her son lived with her. She moved to her previous home in late 1982. Her maternal grandmother died aged eighty-four in 1984. During that year she commenced a new relationship and subsequently became pregnant. The pregnancy was unplanned and she and her partner decided to get married and she remarried in April 1987. Their daughter was born in November 1987. Her second husband was a violent and abusive individual who regularly beat her son from her first marriage. She was reluctant to leave him for some time for fear of bringing shame on her family with her second divorce.

Her father died suddenly from a heart attack in 1993 aged sixty years. She saw a psychiatrist once but decided that 'no amount of counselling' would bring her father back and she abandoned that treatment.

She began attending her current general practitioner in June 1995.

Her son's girl friend committed suicide in 1998 and he became mentally ill. He was hospitalised. He was later diagnosed with a schizophrenic illness and his condition has fluctuated markedly since then and he was subsequently granted a Disability Support Pension.

She resigned from Centrelink in 1998 and accepted a package and took one year off work to provide support for her son who had been diagnosed with Schizophrenia.

According to her treating gastroenterologist, she had a gastroscopy in 1998 due to epigastric pain.

Her abusive second husband left in August 1999 after he told her that he was having an affair. She remained living in her own home.

In 2000 she was approached by a staff member from the Richmond Centrelink office and asked to work as a casual for one day. She had always enjoyed working with customers and this temporary arrangement subsequently became a more long-term situation as Centrelink continued to extend her contract. She was quite successful as a customer service advisor and worked in a number of areas including carers, children, aged care and disability. She had basic New Start knowledge but this was not an area in which she had significant experience. She explained that in the former Department of Social Security customer service staff tended to work in dedicated payment streams as compared to the current cross-training model.

She eventually became a full time employee and contributed to innovative programs including Outreach at a metropolitan hospital for people applying for sickness and disability allowance. She enjoyed working with social workers and loved customer contact.

In 2001 she rented out a room in her house. The house was rented to a recent immigrant from the Middle East. This proved to be a nightmare. He demanded that she sponsor the rest of his family to Australia and she refused to do so. He was physically and verbally abusive to herself and to her daughter, on one occasion holding a knife to her daughter. He also raped her and sexually abused her repeatedly. He threatened to harm her family if she spoke to the police and that if anything happened to him his family would take revenge. He exploited her financially, she eventually gave him to $100,000 and had to increase the mortgage on her house.

She said that over a period of four years ten members of his family arrived in Australia.

She said that during this time work was her refuge and her managers were very supportive. She had contact with the police but was not prepared to swear out a complaint against him because of her fears of retribution. The police kept in touch with her regularly however.

She was attempting to go to a refuge. She saw a psychologist and was funded for thirteen sessions. When those sessions expired she was referred to a psychologist with the Community Health Centre, who saw her at work on a weekly basis. She saw her from about 2003.

She continued to see her until recently. She also had been prescribed Valium taking 5 mg tablets and taking up to three tablets per day, she was also using temazepam to sleep. She was prescribed antidepressant medication briefly but stopped that because it made her too drowsy.

She said her work performance was not affected.

In about May 2005 a new working arrangement was introduced whereby staff was rotated through the Sunshine office from the Richmond office where she worked, to provide them with a broader range of experience.

Her tenant's father became concerned about his potential for violence and fear that he may kill her and ordered him to go back to the Middle East and he left in April 2005 and she has had no contact with him since then. She felt a great sense of relief. She had been having nightmares and flashbacks to various events that had occurred during that experience that slowly settled over the next two years but she remained very fearful about him returning to her life and still has some remnants of those concerns. She heard he later came back to Australia and contacted her daughter once but has made no attempt to contact her.

She was very jumpy and on edge. The counsellor diagnosed her with post traumatic stress disorder.

She continued to work and said that in some ways her job with Centrelink was ‘her saving grace’. She regarded herself as being a competent and conscientious worker and her job and the support she received in that social environment was important for her self-esteem.

In April 2007 she commenced a relationship with her current partner. He was some years younger than her and was working in IT and had a daughter from a previous relationship. She told her new partner about the problems she had had with Omer and he was very supportive. She remained very fearful.

In April 2007 her best friend and work colleague died suddenly. She was shocked but had no time off work. Another colleague died one month later. She was also distressed but again had no time off work.

She subsequently suffered a flare-up of her upper abdominal pain due to stress and was seen in the emergency Department at a metropolitan hospital.

In mid-2007 she was placed on rotation in the Sunshine office from her usual Richmond base.

In November 2007 her partner moved in with her living in a bungalow at the back of the house. She felt much safer for having him on the premises. She said they had a good relationship. Her nightmares and flashbacks and fears about safety had receded. She continued to see her psychologist and occasionally took Valium and temazepam. She was smoking 25 cigarettes per day but was not drinking alcohol and did not use illicit drugs and had no problems with gambling. She enjoyed watching movies, sport, listening to music, going for walks, gardening, cooking, doing housework and was driving regularly in a car with automatic transmission and power steering. She and her partner enjoyed socialising, going to such events as the Comedy Festival.

THE INJURY

Her difficulties began in January 2008 when changes were implemented at the Sunshine Centrelink office that resulted in her being assigned to tasks without receiving appropriate training or adequate support. She had previously specialised in the customer service areas of disability and sickness but was now required to begin undertaking New Start Allowance claims. A senior employee supervised her for two hours preparing two of these claims before she was deemed to be sufficiently competent to meet standard performance expectations. She was left on her own and became increasingly anxious and distressed that she was ill-equipped to meet the demands of clients. The pressure was overwhelming and she thought that it would be hard for anyone to cope in such circumstances, not just herself.

She had always been proud of her ability to provide customers with the best advice possible but found that customers were now passing comments on her apparent lack of knowledge. Her colleagues had been assigned to her previous tasks and also were not provided with adequate training. They constantly sought her advice while she was struggling to master her own work. She had to do nine interviews per day and was uncertain about what she was supposed to be doing. She said there was less staff and more work and 'they burnt me out'.

She began experiencing frequent panic attacks and had several episodes at work. During these episodes she would experience chest pain, a sensation of pressure on her chest, shortness of breath and a racing heart. She would feel hot and sweaty and become shaky and tearful. She would then experience an urge to escape from whatever situation she found herself in. She thought she was having a heart attack.

She began 'hibernating' on weekends and stayed in bed watching television and did not want to go out with her partner. She developed symptoms of acid reflux and her epigastric pain recurred. She had trouble sleeping and worried all night about giving customers the right advice. She was frequently tearful. "I was sick all night."

She had a gastroscopy in February 2008 but no abnormality was found. She took two weeks off in March 2008 for further investigations into the causes of her abdominal pain and anxiety. She was also treated for kidney stones in 2008. Her general practitioner advised her to lodge a Comcare claim but she declined to do so as she did not wish to 'rock the boat'.

Her partner was helping her with the shopping, cooking and cleaning. She was exhausted and unable to cope and was smoking a packet of cigarettes a day.

Throughout this period she was also dealing with personal issues regarding her mentally ill son who had required hospitalisation. She was also caring for her widowed mother and said that most of her absences from work had been related to her duty as a carer. She was living in Caulfield with her partner and her daughter. She said her daughter had had treatment for depression arising from the problems with her former tenant, seeing a counsellor in about 2005 and had overcome her depression. She generally managed these personal difficulties and her work responsibilities. Her work performance reports had always been very good.

She took a month off work between April and May 2008. She was referred for psychiatric assessment by the Commonwealth Medical Officer upon her return to work. Her concerns were discussed with management and she was subsequently transferred back to the Richmond office for eight months where she resumed her previous duties.

She managed her epigastric pain with Zoton and her symptoms improved. She was still prescribed Valium by her general practitioner and was seeing her psychologist on a weekly basis. "I calmed myself, rebuilt myself."

She coped well at the Richmond office and felt that her life was improving. She was sleeping well and had good energy levels and her abdominal symptoms had settled. Her migraines had also settled. She wanted to stay at the South Melbourne office for as long as she could.

On 3 June 2008 she was independently assessed by an occupational physician who made a diagnosis of an Adjustment Disorder with Anxiety in her report dated 18 June 2008 but considered that her condition had now resolved. The occupational physician recommended that she be allowed periods of carer's leave and considered her medically fit to continue her usual work duties as a customer service advisor.

In a report dated 13 October 2008 a consultant psychiatrist, made the same diagnosis as the occupational physician and agreed that the prognosis was good. He noted that she had been in remission for some time but cautioned that it would be difficult to predict how she would deal with a return to the Sunshine office and that she would need training, support and positive feedback for a successful transition.

She was eventually told to return to the Sunshine office with no option and agreed to do this on the proviso that she was supported and trained. She said she was supported via daily contact with her team leader and weekly contact with her manager and felt as though she was being 'spoon fed'. She said 'everything was monitored' for several weeks but was still struggling with the complexity of the applications. She felt as though she was incompetent, which made her anxious. She believed she was being targeted by her manager and supervisor and that they were trying to get rid of her. She was criticised for the amount of time she was taking off work.

In June 2009 she had lithotripsy treatment for kidney stones leaving her with extensive bruising and could not walk at first. She also had removal of a lump from her left breast. She had some physiotherapy to help her walk again and was off work for about four weeks.

In December 2009 she requested one day off work to attend her aunt's funeral. The team leader refused her request. A meeting was held and a decision was made to send her to a Commonwealth Medical Officer. She was angry and frustrated that she had not been able to attend her aunt's funeral .

On 25 January 2010 she vomited blood and presented to the emergency department at The Alfred Hospital to have a gastroscopy and was diagnosed with a stomach ulcer. Dr Kelmann certified her unfit for work for three days and she was subsequently trialled on Nexium and Pariet but these medications were not effective.

When she returned to work she experienced a panic attack. Her general practitioner certified her unfit for work for a further two days and prescribed Valium.

Her manager would not allow her to take time off for medical appointments and she was feeling very distressed. She felt that she was being deliberately targeted.

In April 2010 her team leader told her to stop what she was doing and attend an impromptu five minute meeting in her manager's office. She entered the office and saw all of her medical documentation spread across his desk. Her manager then discussed her medical issues for the next hour and a half and advised her that she would have to have another medical examination to ensure that she was well enough to do the job. She was deeply distressed and in tears. She asked to go home but was told that she was not allowed to do this.

She returned to her desk and a colleague approached her and apologetically informed her that a copy of her medical records had been left on the office printer and had been seen by other staff. She reported a privacy breach regarding this incident. She said the team leader and manager subsequently lied and reported that the printer had been broken at the time of the incident.

She said that she was not able to keep up with the mortgage payment on her home and sold the house in April 2010. She and her partner moved to a rented property.

In August 2010 she received a poor performance review that rated her as 'not effective'. She was shocked and deeply shaken by this assessment outcome. She was then required to undergo a 12-week performance monitoring process. She felt as though she constantly had to prove to the team leader that she was doing her job effectively. She had to provide statistics and evidence to prove that she was meeting expectations and requirements. This was time-consuming and tiring in addition to completing her normal duties. It was also noted in the assessment that she had taken a significant amount of time off work, which she felt was unfair as her absences had been beyond her control and related to procedures for her kidney stones and her breast lump.

In October 2010 she was told to work part-time, four days a week, "in order to improve my health", she was adamant she had not requested part-time work. She said she was still constantly harassed by her team leader and manager. Her ulcer pain increased.

On 23 November 2010 she was called into a meeting with her team leader and manager without warning. Her team leader told her that she had 'passed' the performance monitoring process but warned her that if she did not improve she would be placed on a performance improvement plan and said, "You know what that means". She understood that a performance improvement plan was the final step before termination of employment. She was also told that she would be required to undergo a medical review because she had taken too much sick leave. Thirty minutes later the team leader approached her again to say that the privacy officer wanted to see her the next day in relation to a complaint by a customer about an alleged privacy breach. She hardly slept that night. Upon arriving at work the next day she was advised that her meeting with the privacy officer was scheduled for 2:00 pm. She felt anxious and distressed and unable to cope. She ceased work on 24 November 2010 and was certified unfit for work by her general practitioner on 29 November 2010. The accusation that she had committed a breach of privacy was subsequently withdrawn.

She was worried about returning to work and was unable to sleep. She was frightened of receiving Comcare payments because of the effect on her future employability. She saw her general practitioner again on 14 December 2010 and was prescribed Xylocaine Viscous to treat her stomach ulcer pain and referred to a psychiatrist for treatment. She suffered a frightening panic attack in late December 2010 and her general practitioner prescribed Xanax.

She said she was subjected to continuing harassment and pressure by her team leader and manager even when she was off work. Her team leader telephoned her to enquire about her son's health. She said this had never happened before. It was a private matter and she felt she was still being harassed. She avoided going anywhere near the Sunshine office for fear of having further panic attacks.

In January 2010 she attended the Australian Tennis Open but had a severe panic attack and "passed out". She was resuscitated on site and brought home by her partner.

She was distressed and anxious and had severe burning epigastric pain and vomiting. Her panic attacks persisted and she took Xanax when required. She was also taking Panadeine Forte for back and kidney pains, Xylocaine Viscous, temazepam, Valium and occasional Stemetil for dizziness. She said she cut down her smoking to eight cigarettes a day.

In a report dated 28 January 2011 her general practitioner wrote that her current medical condition was an aggravation of a pre-existing condition and was of the opinion that her employment was the cause.

She first consulted her treating psychiatrist on 14 February 2011. He considered that her work stresses had triggered a Panic Disorder associated with agoraphobic symptoms, making it difficult for her to venture into crowded places unaccompanied. A psychiatrist did not alter her medication and referred her to a clinical psychologist who practised cognitive behavioural therapy. She saw a psychiatrist every week or two.

Centrelink arranged a Section 36 assessment with a gastroenterologist on 17 February 2011 and a consultant psychiatrist on 3 March 2011. The gastroenterologist considered that her symptoms were anxiety related and concluded that she did not have a gastroenterological condition effecting her work capacity.

The assessing psychiatrist considered that she met the diagnostic criteria for Panic Disorder and noted that she had begun to develop symptoms of Agoraphobia in his report dated 11 March 2011. He did not think she was depressed and recommended that she undertake cognitive behavioural therapy to learn strategies to control her panic attacks before attempting a return to work and also commence treatment with an SSRI medication, such as sertraline. The psychiatrist considered her prognosis to be extremely good but noted that there was a risk of entrenched behavioural avoidance if vigorous attempts were not made to return her to work.

On 9 March 2011 Medibank Health Solutions discussed the assessing psychiatrist's recommendations with her and advised her that a clinical psychologist would be able to provide her with the appropriate treatment for panic disorder. The psychiatric report was sent to a clinical psychologist, and she subsequently commenced cognitive behavioural therapy in late March 2011 seeing the psychologist weekly.

In late April 2011 she was advised that Centrelink was appealing her accepted Comcare claim and her condition subsequently deteriorated. She said that Centrelink's statement supporting the appeal contained numerous lies and reinforced her distrust of management and dread of returning to work with her manager and team leader. Her depression intensified and she became highly anxious.

She was required to report to her manager regarding her medical certificates and was provided with an alternative telephone number to contact. She said her team leader answered the telephone, making her feel shocked and uncomfortable.

She had lost all confidence in herself and felt that she needed to regain her strength and confidence before she could return to work. She said that work had been 'a huge part' of her life but discussing a return to work at this stage scared her. She did not have any concerns regarding the nature of the work, as she loved interacting with customers. Her main concern was how she had been treated by Centrelink management and her lack of trust in them. She had felt 'destroyed' by the feedback that she was not effective.

She rarely ventured outside and was spending a considerable amount of time in bed. Her psychologist had recommended that she try to maintain daily activities but she had to force herself to do things, such as visiting her mother who lived in Northcote. She was experiencing significant anxiety in a variety of situations and was fearful of having panic attacks. She had frequent panic attacks and often fled from shopping centres leaving a trolley full of groceries in a queue and had to be accompanied by her daughter. Her psychologist had been working on inducing feelings of panic and encouraged her to do various exposure-based tasks so that she could learn to manage her symptoms more effectively and build her confidence but she was struggling to comply with the tasks.

She was embarrassed by having a compensation claim and felt as though she was worthless and a 'write-off'. She said she was very concerned that her Comcare claim would be rejected because the Centrelink appeal was not 'based on facts'.

Her abdominal symptoms flared up and she continued to be fearful of having a heart attack. However, she had not required her Xylocaine medication as frequently since ceasing work. She was consulting her psychologist, weekly and her psychiatrist monthly and was taking Valium, Xanax and temazepam, and Stemetil to treat symptoms of dizziness.

At the request of Centrelink, an initial assessment was undertaken on 20 June 2011 for the purposes of assessing her workplace rehabilitation needs. That night she experienced a severe panic attack that involved loss of consciousness, vomiting and loss of bladder control. She was frightened that she would pass out again and hurt herself.

The assessing psychiatrist reviewed her on 24 June 2011 and considered that her condition had deteriorated since his last assessment. She was quite dishevelled in contrast to her previous presentation, her affect was flat and she was tearful throughout the interview. In his report dated 3 August 2011 he wrote that she was not currently fit for a rehabilitation program and reiterated that she required treatment for her panic disorder with agoraphobia and depression with an SSRI medication as well as continued cognitive behavioural therapy.

She subsequently commenced taking paroxetine 20 mg daily and her condition steadily improved.

She remained anxious about returning to work and was fearful of being victimised again. She said this was her biggest fear. When she thought about this her mind would start racing again and she would become panicky and need to take Xanax. She was still upset about the way she had been treated and she thought about it frequently. She could not believe that this had happened to her. She had always done the right thing and it was a shock to discover that she was not effective. In the past she had always experienced good relationships with her colleagues and managers but now she no longer trusted the management team and would not speak to them alone. The Union was supporting her and four other employees who had also experienced difficulties with management.

She thought that a transfer to the Richmond office would be the best option as she would then have minimal contact with the manager and team leader. However, this would involve more travelling time to and from work. She still dreaded any contact with them, even by telephone.

She felt mentally drained and her mind was in constant turmoil about work. Her mood fluctuated and at times she felt depressed while at other times she was cheerful. She wondered why everything went wrong for her. Her experience had shaken her confidence in her work abilities.

Her appetite was normal and she had gained some weight since leaving work through lack of activity. She no longer woke during the night but had difficulty falling asleep at times and would lie awake ruminating and then take temazepam. She sometimes found her mind going blank but had no difficulty with concentration. She maintained regular contact with her family. Her friends were mainly workmates and she avoided them because the conversation revolved around work and this induced anxiety.

She described herself as a caring woman with a 'very high tolerance level'. She said she was normally a cheerful individual who enjoyed making people happy.

She moved to her present unit in July 2011 with her partner.

She last consulted her psychiatrist on 16 September 2011 and missed a follow-up appointment scheduled for October 2011. In October 2011 her psychologist told her that she was unable to bill her through Medicare and she would have to pay for the treatment herself. She could not afford to do so and stopped seeing her. She ceased taking in December 2011 because she could no longer afford it. She had occasional telephone contact with her psychiatrist about her use of Xanax.

A return-to-work program was arranged and she was notified that she had been assigned to work at the Coolaroo Centrelink office. She said the location was difficult to get to from her home.

By January 2012 her condition had significantly improved. She said she was feeling much better and had not taken Xanax for one month. She was still seeing her counsellor who she had attended regularly for some time. She was hoping to resume treatment with her psychologist once she received her Mental Health Plan.

She said she was now eager to return to work at the Sunshine office, despite her previous difficulties there. However she was concerned that she was being prevented from doing so because others believed she would not be able to work with her previous team leader and manager. She said that her appeal of her rejected claim was directed at Centrelink and not targeted at the team leader. She believed she could now work with him again and said that she had no personal issues with him. She did not want to work at the Coolaroo office because of the travel involved and because she would be isolated from her support network.

In a report dated 19 January 2012 her treating psychiatrist, wrote that the formal diagnosis of her condition was an Adjustment Disorder with Mixed Anxiety and Depressed Mood associated with panic attacks and agoraphobic symptoms.

An independent consultant psychiatrist, diagnosed her with Panic Disorder, Agoraphobia in remission and Major Depression in remission in a report dated 31 January 2012. The psychiatrist anticipated that she would be able to undertake her full range of pre-injury duties in the next three to six months with a graduated return to work program. The psychiatrist noted that she had very strong views about returning to work at the Ringwood office and believed that placement there was likely to result in failure as it would increase her anxiety and stress. The psychiatrist did not think she should be directly supervised by her previous team leader as she may be prone to further panic attacks.

She went to the Sunshine office on one occasion for a colleague's birthday party and although initially anxious she was greeted very warmly and her anxiety then settled.

She returned to work on 15 March 2012 working four hours per day three days per week doing receptionist work at the Coolaroo office. She felt initially anxious but was supported by the manager and by her work colleagues and has been able to cope with that. She said that she used public transport or drove. It took about two hours to travel to work by public transport and about 75 minutes when driving.

Her hours of work increased to six hours per day three days per week and she was able to manage that.

She ceased treatment with her counsellor on 14 June 2012 as they both felt that there was no need for any more counselling.

She is due to commence working on Fridays from 29 June 2012 for another four hours per week on a one-month trial. She has no other income.

CURRENT CONDITION

Her weight had increased but has dropped to her pre-injury weight. She is now generally sleeping well but still has some mid insomnia in the night before she goes to work and on most occasions feels fatigued in the morning. She finds the travel to and from work quite onerous but is coping with her work and has continuing support from her manager and her work colleagues and the general feedback has been very good. She has not been back to the Windsor office since she returned to work but remains in contact with colleagues from that office.
She is emerging more from her shell and during 2012 has attended two AFL football matches with her partner. She has done a few other activities outside the home.

She spends times with her family and sees her mother in Northcote weekly for a few hours and may take her out. She sees her daughter two or three times per week and has a good relationship with her. Her son has been living with his father since about 2000 and she has telephone contact with him every week. His condition has been relatively stable for the last two months but it is variable. She has contact with her first husband and finds that to be quite amicable. She said that her son lives near her workplace and she sometimes calls in to see him after work. He has also stayed with her.

She has resumed watching sport on television and occasionally live. She said her libido has improved and her sexual activity has returned to normal and she remains affectionate.

She has panicky episodes but no longer has full-blown panic attacks and is less anxious in crowds and away from home. She has occasional nightmares about events about work every few weeks and flashbacks to what happened in the work situation, especially when seein e-mails with the names of the "offenders". She thinks about what happened every day and feels sad and angry about what occurred.

She said she has no nightmares or flashbacks to the events with Omer but would not want to see him and still has some occasional mild anxiety about her safety.

She said she is generally happy but feels flat every two weeks or so during which time her self-esteem and self-confidence drops. She feels restless, frustrated, lonely, isolated, irritable, exhausted, agitated, unmotivated, and has problems with memory and concentration. She is less sociable and has less interest in her appearance on those occasions. Very occasionally she becomes more depressed lasting for a few hours to all day and feels hopeless, helpless, useless, worthless and tearful. She has no suicidal thoughts.

FAMILY HISTORY

She is an only child. Her father, a welder and concreter, died aged sixty in 1993. She is a carer for her frail seventy-three year old mother who lives independently. Her maternal grandmother died aged eighty-four in 1984. Her first husband is now aged sixty-two and is a full-time carer for her son who is aged thirty-three and receives a Disability Support Pension. Her second husband is aged fifty-five and is a construction worker who has little contact with her daughter. Her daughter is aged twenty-four and lives alone in Ormond and is doing a Diploma of Beauty. Her partner is now aged forty-one and has an eight-year-old daughter from a previous relationship.

FAMILY MEDICAL HISTORY

Her father died from ischaemic heart disease in 1993 aged sixty years.

Her son has been diagnosed with Schizophrenia and has had numerous admissions to public hospital psychiatric units. Her first husband was an alcoholic and her second husband was violent and abusive. Her daughter suffered depression following a situation of severe domestic violence between 2001 and 2005 and had some counselling but recovered.

PERSONAL MEDICAL HISTORY

She was subjected to domestic violence by a boarder in her house from 2001 until April 2005 and thought she was going to be killed. In that context she began seeing Melissa Noonan, a psychologist, in 2003 and continued to see her until June 2011. She began experiencing panic episodes and severe anxiety in 2008 and was subsequently treated with Valium and Xanax.

In 2008 and 2009 she was treated for kidney stones. She had a benign lump removed from her left breast in 2009.

She has a history of epigastric pain and was initially diagnosed with a stomach ulcer. She was treated with several medications and found Xylocaine Viscous to be the most effective. She was later diagnosed with stress-induced gastro-oesophageal spasm by an independent gastroenterologist in February 2011. Her treating gastroenterologist agreed with this diagnosis.

She was diagnosed with Panic Disorder with symptoms of Agoraphobia in March 2011 and was eventually treated with Paroxetine 20 mg daily with good effect. She ceased this medication in December 2011.

She had psychiatric treatment between February 2011 and September 2011 and psychological treatment from March 2011 until September 2011.

Her current medication includes Vagifem for hormone replacement therapy and she very occasionally uses Xanax 0.5 mg, Stemetil and Xylocaine Viscous. She smokes 15 cigarettes per day and does not drink alcohol. She does not use illicit drugs. She has had no problems with gambling.

MENTAL STATE EXAMINATION

Appearance and Behaviour

On mental state examination the claimant was a pleasant, polite, punctual and cooperative woman who attended the interview alone. She was of short stature and slim build with long dark hair and was wearing make-up. She was well-dressed. She weighed 58 kg. She had an anxious manner and became tearful during the interview when describing the events at work. She was well orientated

Speech

Her speech was fluent and normal in rate and volume and fluctuated at times when she was feeling distressed. Some rapport was established.

Affect

Her affect was restricted and she appeared mildly depressed and anxious during the course of the interview.

Thought Stream and Form

Her thought stream and form was within normal limits. There was no formal thought disorder.

Thought Content

The content of her thinking was about her ongoing symptoms and the effect this had had on her life. There were no clear suicidal thoughts or intent.

There was no evidence of any delusions (persecutory or otherwise).

Perception

There were no formal abnormalities of perception such as hallucinations.

Cognition

Her attention, concentration, working memory and speed of information processing appeared within normal limits.

Insight and Judgment

There was some insight present. Her judgment appeared to have been disturbed but has improved.

Behaviour

There have been significant changes in behaviour and she has become much more isolated and irritable but this has improved.

OPINION

Jane Doe appears to have been the subject of ongoing harassment and questioning of her confidence during her period of employment at Sunshine office of Centrelink between 2008 and November 2010. As a consequence of that experience she developed an acute Adjustment Disorder with mixed anxious and depressed mood together with panic attacks and some Agoraphobia.

She had a Post Traumatic Stress Disorder arising from domestic violence between 2001 and 2005, having had psychological treatment since 2003. In the period prior to commencing work at the Sunshine office her symptoms of Post Traumatic Stress Disorder had substantially settled and she claims they played no part in her current symptoms.

Her mental state has progressively improved with ongoing treatment to such an extent that she has been able to return to work on a part-time basis in a different office and is coping well with that and is about to increase her hours of work to 22 hours per week. She believes she is coping well with the demands of the work that she is doing at the moment. The work is different to the work that she has done in the past.

Her condition appears to be stable and her prognosis for improvement is generally good.

Her level of impairment has been determined using the appropriate Comcare Guide Table 5.1. She has a level of psychiatric impairment of 5%. This involves:
Despite the presence of **ONE** of the following employee is capable of performing Activities of Daily Living without supervision or assistance:

- reactions to stressors of daily living with minor loss of personal or social efficiency;
- lack of conscience directed behaviour without harm to community or self;
- minor distortions of thinking.

[This report is for medico-legal purposes only and may not be released to the subject of the report or any other party without the permission of the writer]

With kind regards,

Yours sincerely,

Michael Epstein MBBS.FRANZCP

[I have made all the inquiries that I believe are desirable and appropriate and that no matters of significance which I regard as relevant have to my knowledge been withheld. I have prepared my report according to the requirements of the "Expert Witness Code of Conduct" adopted by the Supreme and County Courts of Victoria and confirm that I have read the Code and agree to be bound by it].

[I have also prepared my report according to the following:

Civil Procedure Act 2010
Requirements for Expert Witnesses

The *Civil Procedure Act 2010* ("the Act") came into effect on 1 January 2011. Its main purpose is to reform and modernise the laws, practice, procedure and processes in relation to civil proceedings in the Supreme Court, the County Court and the Magistrates' Court, and to provide for an overarching purpose in relation to the conduct of civil proceedings to facilitate the just, efficient, timely and cost-effective resolution of the real issues in dispute.

To achieve that purpose, the Act outlines a number of overarching obligations. **These apply to expert witnesses in a civil proceeding.** They are:

- **(i) to act honestly.**
- **(ii) to cooperate in the conduct of civil proceedings, with the parties and the court.**
- **(iii) not to engage in conduct that is misleading or deceptive or likely to mislead or deceive.**
- **(iv) to narrow the issues in dispute.**
- **(v) to ensure costs are reasonable and proportionate (being proportionate to the complexity or importance of the issues in dispute, and the amount in dispute).**
- **(vi) to use reasonable endeavours to act promptly, and minimise delay.**

In addition, each person to whom the overarching obligations apply has a paramount duty to the court to further the administration of justice in relation to any civil proceeding in which that person is involved]

Statement of Expertise

Dr Michael Epstein has been a psychiatrist since 1975 and a Fellow of the Royal Australian and New Zealand College of Psychiatrists since 1976. He has an extensive clinical practice which continues. He was the founding director of the Austin Hospital Crisis Service. He was consultant psychiatrist to Fairlea Women's Prison between 1990 and 1996. He was Honorary Secretary of the Royal Australian and New Zealand College of Psychiatrists between 1991 and 1997. He has written extensively on medico-legal matters. He is a co-author of the Clinical Guidelines to the Rating of Psychiatric

Impairment and hence has completed the necessary psychiatric module of the Impairment Training Course for the AMA Guides (4th Edition). He has also completed the neurology module involving Chapter 4 of the Fourth Edition of the AMA Guides. He has trained Victorian psychiatrists in the use of the Guidelines. The Clinical Guidelines have been replaced with The Guides to the Evaluation of Psychiatric Impairment for Clinicians (GEPIC). He is also co-author of the GEPIC and has since trained approximately one hundred psychiatrists in their use. He has been a consultant to the Western Australian Government and a consultant to the Commonwealth Government on Mental Health Service Issues. He has completed training in the Evaluation of Permanent Impairment [Mental & Behavioural Disorders] for the New South Wales WorkCover Authority and the Motor Accidents Authority. He is a member of the Medical Panel and the Forensic Leave Panel and is on the AMA/VWA/TAC Committee. He is on the Victims of Crime Assistance Tribunal's panel of independent psychiatrists. He has a particular interest in stress-related illness.