WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

Issued in accordance with section 294 of the *Workplace Injury Management and Workers Compensation Act 1998*

Matter Number: **1409/17**
Applicant: **Michael Cooper**
Respondent: **State of New South Wales (Ambulance Service of NSW)**
Date of Determination: **19 January 2018**
Citation: **[2018] NSWWCC 14**

The Commission determines:

1. The matter is remitted to the Registrar for referral to an Approved Medical Specialist (AMS) to assess the degree of permanent impairment, if any, as a result of psychological injury deemed to occur on 17 March 2015.

2. The documents to be forwarded to the AMS are those admitted into evidence by consent as follows:

    (a) The Application to Resolve a Dispute and all documents attached.

    (b) The Reply and all documents attached.

A brief statement is attached setting out the Commission's reasons for the determination.

Jane Peacock
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OFJANE PEACOCK, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

Trish Dotti
Senior Dispute Services Officer
By delegation of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. By Application to Resolve a Dispute (the Application) filed 21 March 2017, the applicant, Mr Michael Copper (Mr Cooper), as amended, seeks lump sum compensation as a result of psychological injury alleged deemed to occur on 17 March 2015.

2. The respondent is the State of New South Wales, Mr Cooper having been employed as a paramedic with the Ambulance Service of New South Wales (the Ambulance Service).

3. The Ambulance Service denied liability for the claim.

ISSUES FOR DETERMINATION

4. By way of amendment to the Application, Mr Cooper discontinued the claim for weekly compensation at the arbitration leaving a claim for lump sum compensation as the subject of dispute.

5. Mr Cooper alleges that he suffered a psychological injury deemed to occur on 17 March 2015.

6. Mr Cooper alleges that he suffered a psychological injury in the form of Post-Traumatic Stress Disorder (PTSD) deemed to occur on 17 March 2015.

7. In fact, his claim for lump sum compensation is based upon the report of Assoc/Professor Robertson, psychiatrist, dated 4 August 2016 who opines that Mr Cooper suffers from a "substance use disorder (alcohol dependence) with cross cutting features of PTSD" which he considers "emerged in the course of his duties as a paramedic".

8. The Ambulance Service disputes that he suffered such an injury and/or that his employment was a substantial contributing factor to the injury. As per the section 74 notice dated 11 January 2017, the Ambulance Service notified that they were of the view "that the evidence does not support (Mr Cooper) suffered injury in accordance with s 4 and 9A of the *Workers Compensation Act 1987* (the 1987 Act).

9. If Mr Cooper is found to have suffered such an injury, the Ambulance Service relies upon section 11A of the 1987 Act and says that Mr Cooper cannot recover compensation because his psychological injury was wholly or predominately caused by the reasonable action of the employer taken in relation to performance appraisal or discipline (as per the section 74 notice dated 11 January 2017).

PROCEDURE BEFORE THE COMMISSION

10. The parties attended a conciliation conference/arbitration hearing on 14 June 2017 which was adjourned for further hearing on 8 August 2017. The parties were both legally represented. Mr Hammond of counsel represented Mr Cooper and Ms Wood of counsel represented the Ambulance Service. Following the arbitration hearing I discovered that a document entitled "Expert Guidelines for the Diagnosis and Treatment of PTSD in Emergency Service Workers" referred to in the report of by one of the expert witnesses, namely Dr Abeya was not in fact attached to the report. Accordingly, for the sake of completeness that report was directed to be filed which was duly attended to by the Ambulance Service on 22 September 2017. To accord the parties procedural fairness they were both given the opportunity to make written submissions on that document which the parties did on 18 October 2017 and 19 October 2017 respectively. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of

any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Documentary evidence

11. The following documents filed by the parties were admitted into evidence before the Commission by consent and taken into account in making this determination:

    For Mr Cooper

    (a) The Application and attached documents.

    For the Ambulance Service

    (a) Reply and all attached documents.

12. In addition, the report of Dr Abeya, psychiatrist dated 22 January 2016 had referred to a document entitled Expert Guidelines for the diagnosis and treatment of post-traumatic stress disorder in emergency services workers". That document was not attached to the report. The respondent was subsequently directed to file that report in evidence for the sake of completeness and in the interest of procedural fairness both parties were given the opportunity to make written submissions on that document as per my direction dated 5 September 2017 as follows:

    "It is noted that an arbitration was held in this matter during which counsel for both parties made submissions.
    1. In the course of her the submissions Counsel for the Respondent referred to the report of Dr Abeya dated 22 January 2016 and quoted extensively from that report.
    2. The report of Dr Abeya refers to the "Expert Guidelines for the diagnosis and treatment of post-traumatic stress disorder in emergency services workers". This reference is contained in Dr Abeya' "Summary of Findings" (page 50 of the Application to Resolve A Dispute), however the Guidelines are not attached to the report.
    3. Noting the reliance placed by Counsel for the Respondent on the report of Dr Abeya and that the report of Dr Abeya was in fact commissioned by the Respondent (although it was filed in the Applicant's case), the Respondent is directed to file and serve within 14 days (that is, by 4pm 19 September 2017) a copy of the "Expert Guidelines for the diagnosis and treatment of post-traumatic stress disorder in emergency services workers" referred to by Dr Abeya in her report.
    4. To accord procedural fairness to the parties, the parties will each have the opportunity to provide written submissions (within a further 14 days each) in relation to the additional document as follows:
        (a) The applicant by 4pm 3 October 2017
        (b) The respondent by 4pm 17October 2017".

Oral evidence

13. Mr Cooper did not seek leave to adduce further oral evidence and the Ambulance Service did not seek leave to cross-examine Mr Markham.

FINDINGS AND REASONS

14. Mr Cooper alleges that he suffered psychological injury in the course of or arising out of his employment as a paramedic with the Ambulance Service deemed to occur on 17 March 2015 and that his employment was a substantial contributing factor to his injury.

15. The Ambulance Service disputes that he suffered a psychological injury in the course of or arising out of his employment and that his employment was a substantial contributing factor to his injury.

16. In the event, that Mr Cooper is found to have suffered a psychological injury, the Ambulance Service relies on section 11 A of the 1987 to assert that Mr Cooper is precluded from recovering compensation for his psychological injury because it was wholly or predominantly caused by the reasonable action of the employer in respect to discipline or performance appraisal.

17. Turning then to an examination of the evidence in the case.

18. Mr Cooper gave evidence in a statement dated 1 August 2015 and in a further statement dated 28 February 2017.

19. Mr Cooper was not cross-examined about his evidence.

20. Mr Cooper commenced employment with the Ambulance Service as a paramedic in 2005.

21. Mr Cooper gave evidence that prior to his employment with the Ambulance Service he has previous history of anxiety/depression in 2002 when his business, which he had operated for many years, went into liquidation, He was prescribed antidepressant medication during this period and after about six months he made a full recovery.

22. He was not cross-examined about this evidence and there is no evidence to controvert his statement that he made a full recovery.

23. All of the doctors whose reports are in evidence were made aware of this prior history.

24. He went onto obtain work as a lifeguard and then obtained full time employment with the Ambulance Service in 2005.

25. Part of the Ambulance Service's case is the allegation that Mr Cooper had a pre-existing alcohol abuse problem.

26. Mr Cooper gave evidence at paragraph 9 of his statement dated 1 August 2015:

> "Prior to my employment with NSW Ambulance, to my knowledge, I had never been medically advised regarding my alcohol consumption.

27. Mr Cooper was not cross-examined about this evidence and no medical evidence from doctors who may have treated Mr Cooper prior to his employment has been put before me to controvert this statement.

28. Mr Cooper gave evidence that in his observation the NSW Ambulance Service is understaffed, and paramedics are unable to take their crib breaks (each twelve-hour shift comprises two thirty-minute crib breaks). Mr Cooper gave evidence that he would routinely work twelve hour shifts without taking a designated crib break. He gave further evidence:

> "At the completion of a twelve hour shift, I have very often had to undertake extension of shifts because of a heavy workload and being understaffed"

29. There was no evidence put before me to controvert Mr Cooper's statements about the workload pressures he was placed under in his employment.

30. Mr Cooper gave evidence that upon commencing employment with NSW Ambulance, he attended a twelve-week course and then completed a nine-month probationary course. He was then first stationed at Urbenville (near the QLD/NSW border) for about five months.

31. In 2007 he was posted to the Holbrook ambulance station for two and a half years,

32. Whilst stationed at Holbrook, he gave evidence that he was regularly required to attend victims of serious motor vehicle accidents on the Hume Highway.

33. He gave evidence that the nature of the work he conducted as a paramedic often left him feeling psychologically scarred. He gave evidence that the culture of the workplace was that you continued working as a paramedic notwithstanding any psychological affect. He stated:

> "However, my observations of the working culture of NSW Ambulance is that a paramedic's role is to conduct duties that may have a negative psychological impact on the paramedic, and accept that this is a part of the job and continue working even when psychologically affected by work related experiences."

34. Counsel for the Ambulance Service opened her submissions with the observation:

> "The applicant claims that he is suffering from a post-traumatic stress disorder and that his alcohol difficulties are as a result of stressful periods of his work. The respondent submits that there is no contemporaneous medical evidence of the applicant having reported difficulties with his employment in terms of any of the stressful events that he describes in his statement."

35. Mr Cooper gave evidence of what he had observed of the culture of the Ambulance Service and that he understood the expectation to be that you continued to work notwithstanding any psychological affect. He was not cross-examined about this explanation.

36. Counsel for the Ambulance Service submitted:

> "The applicant was clearly attending a general practitioner and that general practitioner I think was Dr Maher who provides a report at page 56 of the Application to Resolve a Dispute. There is a referral dated 2 March 2016 to Dr Wade and we have Dr Wade's report and we know that Dr Wade, the first treating psychiatrist engaged to treat the applicant didn't see the applicant until 19 April 2016."

37. However, it is not for a lay person to diagnose that he is having mental health problems associated with his exposure to trauma. Moreover it appears from the evidence that the first treating professional to diagnose that Mr Cooper was suffering from PTSD was a psychologist Barbara Elrlich and it was upon this diagnosis that his initial notification of injury was based in June 2015. Moreover, this diagnosis of PTSD was also made by Dr Potter in his report dated 16 September 2015, a psychiatrist to whom the insurer had referred Mr Cooper after the notification of injury. Dr Potter diagnosed "Chronic Post Traumatic Stress Disorder and Co-morbid Substance (Alcohol) Abuse". Dr Potter considered that Mr Cooper's chronic PTSD resulted from "his exposure to the trauma of Ambulance Work". Given this support for Mr Cooper by its own IME, Dr Potter; the insurer initially accepted liability for the claim, which they subsequently withdrew.

38. Mr Cooper gave evidence that there were "numerous work related incidents" that affected him psychologically. He gave evidence that in 2007 he was psychologically affected by the

death of a baby, being the first incident that caused him "to cry and feel grief". He gave evidence as follows:

> "one of the numerous work-related incident that affected me psychologically occurred when I was stationed at Holbrook in about 2007. I had only been a paramedic for about 18 months at that time, and I received a call to attend at a residence by myself where a mother had fallen asleep and rolled onto her eighteen month old baby. When I arrived at the residence, I observed that the 18-month-old girl was in cardiac arrest, I attempted to resuscitate the girl, but she died as I did this. The mother began screaming with howls of grief when her baby died. This was the first incident that caused me to cry and feel grief."

39. Mr Cooper explained that he did not report how he was feeling but he worked on and carried the memory of the dying baby girl with him. He gave evidence:

> "I did not report the way I felt to my colleagues or superiors at the NSW Ambulance and carried on with my duties as if the experience had not affected me, I felt that this was what was expected of me, but I carried the memory of the dying baby girl with me, and the memory of my experience did not fade with time."

40. Mr Cooper went on to detail another particularly traumatic experience that haunted him, this time involving the death of a teenage girl:

> "In approximately 2007/2008 whilst stationed at Holbrook, a teenage female that was attending Bathurst university was texting to her father while driving her car when she crashed. I attended the scene with another paramedic and we transferred the female to Albury base hospital, where the female died after arrival. I recall going to rear of the ambulance section of the hospital to wash the deceased female's blood from the spine board. As I was washing the female's blood off the spine board, the deceased female's mother came running up to me as I was washing the spine board and asked me in words to the effect of:
>
> "Did you bring my daughter in?"
>
> I remember that I just froze and could not reply to the mother. The incident affected me mentally for a long period of time afterward, but I never reported this to NSW Ambulance as, again the work culture appeared to be that this type of psychological injury was to be carried as part of the job."

41. Mr Cooper gave evidence that about the end of 2008 he was posted to the Hunter region where he worked at various stations since that time.

42. Mr Cooper gave evidence of another traumatic event to which he was exposed which had a "heavy emotional affect" on him, this time involving the death of an eight-year-old girl Jasmine Kite, who died in his arms upon arrival at the John Hunter Hospital. He gave evidence that he attended her funeral and "wept with grief for her". This event occurred in about 2009 whilst he was stationed at Merewether.

43. He gave evidence that "…again, I did not report how Jasmine's death had psychologically affected me and just continued in with my duties as I thought this was expected of me".

44. Mr Cooper says "the psychological trauma that I was suffering from due to my experiences at such incidents began to affect my marriage and family relationships." He began to isolate himself socially and stopped playing touch football and surfing. He says:

> "From about 2010, I began to isolate myself socially, even towards my family, at the completion of a shift, I would return home, cook the family dinner, and then retreat to

the garage and sit by myself until I was ready to sleep. It was about this same time that I started to self-medicate by drinking alcohol almost every day. I quit my membership at the surf club, playing touch football and going surfing".

45. Mr Cooper gave evidence that in about November 2012, he separated from his wife after twenty years of marriage.

46. Mr Cooper says in about November/December 2012, the chaplain (from the NSW Ambulance Service) called him to enquire how he was feeling because of the separation. Mr Cooper told the chaplain that he was regularly drinking alcohol as a stress relief mechanism. The chaplain recommended that he inform NSW Ambulance of his issues with alcohol and Mr Cooper agreed to this.

47. Mr Cooper says that he continued to experience work-related stress issues and personal stress issues from that time but received no further contact from the ambulance service to assist him.

48. He says that "throughout this period of time and up until August 2014, he had been drinking alcohol on a daily basis as a coping mechanism. I had also continued to completely isolate myself socially".

49. His alcohol use interfered with his ability to work. He stated:

> "At about this time, when I was rostered on night shift. I found it very difficult to not drink alcohol prior to my starting time of 7pm, and as a result, I would sometimes call in sick prior to my shift commencing because I had been drinking alcohol and would not be capable to conducting my duties".

50. In about mid-September 2014, the Assistant District Officer Ken Isles paid an unscheduled visit to Mr Cooper's residence in the morning to find Mr Cooper "crying as I sat in front of my computer. At the time, I was very emotionally distressed."

51. Mr Cooper said that Mr Isles recognised that Mr Cooper was psychologically ill and actioned a meeting with Mr Hescott and Mr Akester the following day. Mr Cooper attended the meeting and said he asked to undertake the Lifestyle program but this request was not supported.

52. Mr Cooper gave evidence:

> "As NSW ambulance would not admit liability or take responsibility for my psychological injury as being a work related injury, it was agreed between me and NSW Ambulance Management that from 22 September 2014 to 26 September 2014 I would book myself into Lakeview Detoxification Unit to address my issues of alcohol abuse and then return to alternate duties at Hunter New England Section office, Tighes Hills under the supervision of Mr Akester."

53. On 30 September 2014 he commenced alternate duties at Hunter New England Section Office on a projected roster which entitled him to receive his weekend penalty rates.

54. He says:

> "On 9 October 2014, a psychiatrist at the Mater Hospital Drug and Alcohol unit, assessed me for eligibility for the healthy lifestyle program. The assessment recommended that I commence the program. I made application to NSW Ambulance management to attend the healthy Lifestyle program, but NSW Ambulance declined my request to attend the program. I am not aware of the reason for NSW Ambulance refusing my request and I felt a lack of support toward me on their behalf."

55. He gave evidence that he felt deliberately isolated and excluded by managers Robert Akester and Jeffrey Hescott from the time that he commenced in alternate duties at Hunter New England Sector office.

56. On 7 November 2014 he was required to attend for independent psychological assessment Dr Abeya (whose report is in evidence) and he says he informed the psychiatrist about the issues of social isolation and harassment that he had been subjected to.

57. After the IME report (from Dr Abeya) was revealed, an informal meeting was arranged to discuss. “At the informal meeting Jeffrey Hescott informed me that he was extremely displeased that I had disclosed that I felt I was being isolated and harassed in the workplace to the IME examiner”.

58. On 12 December 2014 he attended a meeting with management to discuss the formulation of his Return To Work (RTW) Plan and on 15 December 2014 he was provided with a RTW plan.

59. On 1 January 2015, his salary was reduced to a base rate which he says caused financial hardship and he could not afford to attend a GP once a week and counsellor twice a fortnight as per the RTW plan because he was on a base salary and his economic commitments were based on his on-road salary.’ There are various emails in evidence which show that Mr Cooper telling the Ambulance Service that his change in salary was causing him financial hardship because, for instance, his child support was calculated by the Child Support Agency on his on-road salary.

60. He says he was desperate to return to on-road duties:

> “As my economic commitments required me to earn an on road salary I make and so I was desperate to return to on road duties whether I was psychologically healthy or not.”

61. On 24 February 2015 he attended the next scheduled IME in Sydney (Dr Abeya) and informed her that he was ready to RTW on on-road duties and that he had returned to normal health.

62. Dr Abeya supported a RTW to work to on-road duties to be reached in stages.

63. On 24 March 2015 he returned to on road duties working staged starts until 20 April 2015 when he returned to full-time duties with overtime.

64. Mr Cooper then goes onto to give evidence about exposure to further trauma when he returned to on-road work when he was involved in an incident on 13 April 2015 in which he feared for his life. He gave evidence as follows:

> “55. On or about 13 April 2015, I was working an on-road dayshift with my paramedic partner, Bianca Keats, and had been called to attend to a female patient at the corner of the New England Highway and South Seas Drive, Ashtonfield NSW. The female patient had reportedly been stabbed by her partner.
>
> 56. We arrived at the scene and began treating the stabbed female patient in the driver’s seat of her vehicle, a van, which contained her six children in the rear of the van.
>
> 57. NSW police had apprehended the assailant, who I believe was the female patient’s partner, and had handcuffed him with his hands in front of him and put him into the rear of a police car.

58. As I was trying to calm the female patients six children in the rear of the female patient's van, the assailant managed to jump into the driver's seat of a NSW police vehicle and started during the NSW police vehicle straight at the female patient's van and where I was standing next to it, in what appeared to be an attempt to ram the NSW police vehicle into the van.

59. I was extremely fearful for the children's lives, as well as my own van, as the NSW police vehicle that the assailant was driving approached the van in an out of control manner.

60. the assailant missed the van by a small margin and kept on driving past the van, crashing and coming to a halt while attempting to turn the NSW police vehicle around.

61. Bianca and I were both visibly shaken immediately after this incident."

65. Mr Cooper goes on to give evidence that he called the District Operations manager Pearce Benson to come to the site of the incident as a support person for Bianca and me. Mr Benson arrived at the site and spoke to the rescue team employees first in preference to Mr Cooper and his partner and cleared the site before he spoke to them, Mr Cooper said he

> "…was appalled that Mr Benson had not consulted with Bianca and me prior to giving clearance of the site".

He goes onto explain:

> "Mr Benson then drove his vehicle back to where Bianca and I were located and, as Mr Benson had already cleared the site, we both told Mr Benson that we were fine, and he left the site of the incident soon afterwards. I was very shaken up by what had occurred, but again, I did not report my feeling to NSW Ambulance."

66. Mr Cooper goes onto give evidence of a further experience that caused him "great anxiety" and had him "fearing for my own life" as follows:

> "On or about 20 April 2015, I was working a night shift as severe weather was battering the Hunter Region area. During our shift that night, we worked through intense rainfall and wind, with trees and power lines falling alongside the road side, and unidentified objects impacting with our NSW Ambulance vehicle as we drove. I recall having to attend to a patient outside our vehicle that night and the weather conditions I was working under caused me great anxiety, fearing for my own life. I did not report my feelings of anxiety at the end of my shift."

67. Mr Cooper gave evidence that on or about 1 June 2015 he watched an ABC Four Corners program regarding alleged murders that took place on a ship named Sage Sagittarius in or about 2012. He recalled being the first paramedic to board that ship when it docked in Newcastle harbour. There had been no mention of foul play at the time. It appeared from the program that the murderer had in fact been on board at the time Mr Cooper boarded the ship. He gave evidence that he "found the incident and the information about the incident on Four Corners very disturbing".

68. He gave evidence that on or about mid-April 2015 he stopped his medication for depression as he says he was unable to afford a new script. He did not report this to NSW Ambulance.

69. He says he broke down emotionally after working a night shift finishing at 7 am on 7 May 2015 at Beresfield station. After completing his shift, his car engine blew up. He says:

> "I broke down and started crying, and felt like my world had fallen apart. I felt that I could not report the breakdown to NSW Ambulance, as I would have been taken off

road again, earning reduced salary, so I did not report how I was feeling to NSW Ambulance."

70. He says:

> "As I was not taking my medication. I began drinking alcohol to self-medicate my medical condition."

71. On 17 May 2015 he had an argument at home and says that in frustration he drank a beer just before his shift commenced. At work he was asked to undertake a breath test which he refused because he knew he would be over. He was stood down immediately and sent home.

72. He says:

> "I had never previously failed any of the numerous breath tests that I had been required to undertake and I have not failed any since returning to work".

73. Mr Cooper gave evidence:

> 78. "On 18 May 2015 Mr Akester telephoned me and informed me that I had been stood down permanently until my refusal of taking a breath test issue had been investigated for misconduct by PSCU.
>
> 79. On 4 June 2015 I consulted with my (GP) Dr Max Maher, who referred me to psychologist Dr Barbara Elrich.
>
> 80. On 6 June 2015, I consulted with Dr Erlich, who recommenced that I submit a NSW WorkCover claim for my condition of ongoing PTSD, which I submitted to NSW Ambulance on 8 June 2015."

74. On 12 June 2915 he was given a letter from NSW Ambulance that he had been charged with misconduct for refusing a breath test.

75. He was given the opportunity to make submissions in support of his case,

76. He goes on to give evidence:

> "83. On or about 1 July 2015 I completed my written submission for the NSW ambulance CEO and sent it to the NSW ambulance to proof read it for me.
>
> 84. That same evening I took a large quantity of Valium, which has been prescribed by my doctor to overcome withdrawal from alcohol, as I just wanted to knock myself out.'
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> 85. On 2 July 2015, I consulted with Dr Max Maher. After consulting with Dr Maher, I went to the pub and drank alcohol until I was heavily intoxicated. I returned home and while intoxicated I telephoned family members and informed them that I felt like taking my own life"

77. A family member telephoned NSW Ambulance and two ambulance officers arrived and Mr Cooper was transported to Mater hospital by ambulance and put into an emergency overnight stay unit.

78. He was psychiatrically assessed and involuntarily scheduled.

79. He was released on 6 July 2015.

80. At the time of his statement (8 August 2015) he noted that he resumed taking his medication (Sertraline) and was making steady improvements with his mental health condition. He noted he was "currently on alternate duties at Hamilton ambulance station" and that he wished to return to on road duties as soon as possible.

81. Mr Cooper did not ever return to on-road duties. I note that Dr Abeya and Dr Potter who provided reports for the Ambulance Service did not support a return to work which would expose him to further traumatic incidents.

82. Dr Potter, IME for the insurer, in his report dated 16 September 2015 opined:

> "His prognosis is guarded. Although he wishes to return to ambulance work, quoting financial reasons, in accepting a chronic PTSD related to his traumatic ambulance work, it will be clinically inappropriate for him to undertake any work which constantly reminds him of his exposure to human morbidity and mortality."

83. Dr Abeya, psychiatrist, to whom the Ambulance Service sent Mr Cooper for her to assess fitness for work as a paramedic, considered in her third report dated 22 January 2016:

> "It is clear that considering any immediate return to work as a paramedic would pose a risk both to Mr Cooper (of exacerbation of his PTSD-like symptoms) and to others (if he were in an intoxicated state)."

84. In a further statement dated 28 February 2017, Mr Cooper recounts in more detail the traumatic incidents which had the most potent effect on him.

85. He gives evidence of the significant trauma to which he was exposed and the effect it had on his state of mind. He was not cross-examined about this evidence.

86. He recounts various incidents whilst stationed at Holbrook. The first day on the job at Holbrook which he describes as his "first shift, day 1" involved attending upon a local man (Ray) who had been hit by propeller after his ultralite jumped its clocks. Mr Cooper recounts:

> "On arrival we found him lying on the tarmac with horrific injuries to various parts of his body, the blade had degloved (removed) all the skin and muscle from his back to the point where you could see his spine and his right arm had been almost completely severed. We did what we could and rushed him to Holbrook hospital where he was stabilised and flown to Canberra Hospital. Ray survived but it will be a long time before I forget the look of his back."

87. He recounts in detail the attending upon the baby whose mother had rolled on her in her sleep while breastfeeding. Mr Cooper was on his own and was a paramedic intern who had been in the job less than a year when this occurred. He gives evidence:

> "The next incident happened early one morning after I just turned up to start my shift. I was on my own as my fill in partner had had a late night working and was running late, It was a little after 8am that I received a call from the co-ordination centre (Co-ord) and the dispatcher was in a distressed state, which was highly unusual, I understand why now, as he was about to send a paramedic intern who had been in the job less than a year to a cardiac arrest in an 8 month old child on my own and my nearest back up was in Albury some 40 minutes away even at high speeds under lights and sirens, I raced out and remember as I pulled up hearing the child's mother wailing in agony in the front yard, She had been breast feeding the child and had fallen asleep and rolled over the infant crushing. I tried to block out her screams as I had a job to do, but I will never forget them". The child was pronounced dead on arrival at the hospital.

88. Mr Cooper goes onto give evidence that procedural change was then affected within the ambulance service such as paramedic interns should never be left to responds single and that there should be an immediate stand down from service for the day after an event like that. He says the district officer wasn't even made aware of the event till after 5 pm that day and that he received no counselling or support. He said, "that was the first night as a paramedic that I cried myself to sleep".

89. He notes that Holbrook sits on the Hume Highway and "the local truckers call it sesame street because of the cowboy behaviour of some of the young truck driver. If I was to tell you all I saw on the roads down there this would turn into a novel. But I will relate a few of the more hurtful incidents."

90. He goes onto describe "the one that hurts the most and still does to this day" is when he was called to a MVA of the young girl driving to Bathurst to attend university:

> "It was the first time her parents had let her drive on her own. Her mum wasn't happy, but her dad convinced her that it would be okay. Apparently, she was texting her father to say all was well when she lost control of the car and hit a tree. Unfortunately, the trees out in the bush are very unforgiving. Our crew was not the first on the scene, the fire brigade crew had already removed the roof of what was left of the car. I was immediately asked to take over trying to ventilate her. The problem was that she had no recognisable face, no nose, no mouth etc., it just looked like mush. I did what I could, but I was aware that what I was doing was useless. She was cut out of the car and raced to the Albury hospital where she was pronounced 'dead on arrival".

91. Mr Cooper goes onto recount that for him the worst was yet to come, and he evinces the distress he feels on recount: (emphasis is Mr Coopers)

> "Unfortunately for me the worst part was yet to come; (*and thank you again as I am crying as I write this !!!)*, we were outside Albury emergency cleaning up the car. There was so much blood on the spine board that I had no choice but to use a hose to wash it. As I was doing this an hysterical woman ran up to us and asked if we had brought in her little girl, as I washed the blood of her dead child off the spine board. Luckily there was a district officer with us who led her away, but I was speechless. Weeks later the local paper ran a story on why you shouldn't text and drive and it included a full page shot of this young girl. I still to this day cannot look at it, that was the second time as a paramedic that I cried myself to sleep."

92. Mr Cooper goes onto give evidence about another incident involving the death of a young man in an MVA when he was on his way to his year 12 formal. The young man had been ejected from the vehicle in the accident. Mr Cooper was instructed to begin chest compressions but "the problem was every time I pushed down on his chest blood spurted out his ears, we knew straight away that he had broken the pallet between the top of his mouth and his brain, we realised that this young man was going to die."

93. Mr Cooper relates that the biggest issue was the arrival of the family:

> "The biggest issue was that he crashed only kilometres from his property so within minutes his family had turned up. I asked Mark (his senior officer) what to do and he instructed me to keep working on him even though there was nothing we could do just so the family thought we were doing everything we could. As an intensive care paramedic Mark had the right to declare the patient deceased, and after some time he did. The family accepted this but asked if they could see their son before we took him away, the problem was he was covered in blood, so on a late hot summer night Mark Davis and I played mortician and cleaned up this body enough so his parents could say goodbye, I'm not sure but if that is in the training manual. And the poor boy was on his way to his year 12 formal, and we still don't know what caused the accident."

94. Mr Cooper said that the amount of road trauma on the Hume Highway that he was exposed to whilst working at Holbrook was considerable but he has given evidence in detail about the worst ones which involving the kids "and kids always hurt the most". He gave evidence:

> "As I said I could talk about the road trauma I witnessed whilst working in Holbrook for days, I saw many dead bodies wrapped around trees and the like. I mentioned these two incidents in detail because they were kids and kids always hurt the most. One evening we got called to a man run over by a trailer, the trailer turned out to be the rear bogie of a B double semi-trailer> ever seen what 10 tonnes of truck can do to a body, his entire lower abdomen was in his chest. Not a pretty sight. Another afternoon we got called to a three vehicle accident which turned out to be a small 4WD squashed between two semi-trailers, and one of the semis had caught fire. When we arrived what we saw can only be described as post-apocalyptic, the male driver of the 4WD dies. One wet afternoon we got called to a car rollover and the details included a baby in a cardiac arrest, a young girl with severe head and chest injuries and an older woman with an amputated leg. Upon arrival, the baby was breathing thanks to an off-duty nurse from Albury Base Hospital, the older woman was lying in a pool of water while a bystander held her leg up that had lost her foot just above the ankle. As I said I could go on and on, but this has been hard enough already."

95. Mr Cooper goes onto give evidence that in 2008 he was transferred back to Newcastle.

96. He gave evidence of a significant traumatic event involving the death of an eight –year-old in 2010 that he believed was the straw that broke the camel's back. He gave evidence as follows:

> "Sometime in early 2010 we got called to a job that I still believe was the straw that broke the camels' back and that was the death of Jasmine Kite. My partner and I were sitting at the John Hunter Hospital (JHH) when Co-Ord asked if could clear to attend a MVA at Merewether Heights, we were backing up the Hamilton rescue truck and from the first on scene report we could tell something was seriously wrong. Upon arrival we found a paramedic and an off duty anaesthetist desperately working on an 8 year old girl, who was unconscious and as white as a ghost. A third intensive care ambulance turned up just after we arrived and as the anaesthetist was unable to gain Intravenous access the decision was made by Dave Reid to "upload and go", I travelled in the back of the ambulance and I was in charge of ventilating the patient. During transportation the child's heart rate dropped to 28. In our training we had always been told that Bradycardia in a paediatric is a pre-terminal event. I told Dave and he told me to start CPR immediately. We relayed this information to the hospital via the radio, not realising the mother of the child was in another car and would have overhear the transmission. Upon arrival at the JHH there were 11 doctors waiting for us in resuscitation bay and everything was done in a vain attempt to save this little girls life.

97. Mr Cooper gave evidence of the irreversible effect this terrible event had upon him:

> "When they finally called it because she was dead, a little part of me died with her. It turned out she had slit her liver in 5 places and was never going to survive. Once again, I never received any formal debrief or counselling following this event, I went home, grabbed a beer and sat on my kids trampoline and cried, it was up to my then wife to hold me and try to keep me together, but I believe I have never been the same since".

98. Mr Cooper gave evidence that it was following this event that he started drinking heavily and isolating himself socially. He gave evidence:

> "It was following the Jasmine Kite incident I started drinking heavily. I began to socially isolate myself my drinking was sporadic at first and I mainly used it to assist with my nightmares and inability to sleep.
>
> As time went on I used alcohol to medicate myself for anxiety. If I was drunk I wasn't anxious and I was becoming anxious all the time."

99. Mr Cooper has given very clear evidence about the traumatic event that in his words "was the straw that broke the camel's back" and "where a little part of him died along with the little girl and that he believes caused him to escalate his drinking to self-medicate for nightmares, insomnia and anxiety, namely the death of Jasmine Kite in 2010. Mr Cooper was not cross-examined about his evidence. This history of an escalation in his drinking in in 2010 is consistent with the evidence that has been given to all the doctors whose reports are in evidence.

100. Mr Cooper goes onto give evidence about what he feels the effect of his injury has been upon him:

> "So far, this disease or disorder called PTSD has cost me my marriage, my financial status, nearly all my family and friends, it has severely affected both my physical and mental health, including many trips to the hospital and one suicide attempt. And finally, it has stripped me of the career that I loved and was very proud of."
>
> Before joining the Ambulance Service, I was a professional lifeguard and chief instructor at Birubi Surf Club, I have trained many life savers and saved many lives. Now I am too anxious to go into the water above my waist. I have been riding motorbikes since I was a child, now I am too anxious to get on one. I hate waking up and struggle every day to get out of bed, and rarely leave the house. I no longer surf, ski or do anything I used to enjoy so much. I am a fraction of the man I used to be, let me assure you nobody wants or asks for this. I was not a heavy drinker prior to 2010 I did drink socially but not to excess."

101. Mr Cooper feels unsupported by the Ambulance Service. He gives evidence:

> "Between 2013 and 2015 various ambulance service employees would ring me up and do welfare checks or breath test or the like, I cannot recall one of them ever asking how I was, save and except in relation to my alcohol consumption. They didn't ask me about my nightmares, they didn't ask me about my anxieties and they didn't ask me when or why I started drinking".

102. Mr Cooper gave evidence:

> "I still have nightmares and flashbacks. I still struggle to drive anywhere outside my local neighbourhood on my own. I still drink to help me to sleep. I do not like people. Nor do not like social situation, I am hyper vigilant to the point of being freaked out by the smallest thing."

103. On 2 March 2016 Mr Cooper was referred by his treating GP Dr Maher to his treating psychiatrist Dr Wade. The terms of that referral noted as follows:

> "Thank you for considering seeing Michael Cooper, age 52 years, who has been a patient of mine for approximately 1 year. He came with a h/o-? depression and ETOH dependence, He had been stood down for work as a Paramedic due to then ETOH problem. He made a claim for workers compensation late in 2015 for PTSD. He has a claim number and has a psychiatric assessment from Dr B Potter in Sydney agreeing with this diagnosis. He told me last week that he has been terminated from his employment after a disciplinary hearing. He ETOH use disorder is ongoing."

104. Dr Wade therefore has the benefit of this history of ETOH use disorder and the termination from work as a result when he saw Mr Cooper. Dr Wade saw Mr Cooper on 19 April 2016 and provided a report back to Dr Maher on 20 April 2016. Dr Wade, as his treater, comes to an unequivocal diagnosis of PTSD that has become chronic. He opines:

> "He said he always wanted to be an ambo, a paramedic. Currently Mick said he doesn't trust anyone, He said Brian Potter who was working for QBE was the first to diagnose his PTSD. It would appear now it is Chronic PTSD having suffered the disorder now for a number of years. It would appear that his alcohol use is purely self-medication, trying to change mental and emotional gears. He certainly ticks all the boxes diagnostically for PTSD. There are elements there of minor depression. The huge issue was isolation, the alienation and the avoidance. The huge lack of the things that he is not doing all based on fear, but the irrational fear coming from the PTSD."

105. Dr Wade proposed treatment by way of psychotropic medication and psychiatric review.

106. I note that Dr Wade, as the treating psychiatrist, diagnosis that Mr Cooper's PTSD was chronic is consistent with the diagnosis of Dr Potter, the IME for the insurer, who in September 2015 considered that Mr Cooper's PTSD was chronic in nature.

107. Mr Cooper saw Assoc/Professor Robertson who was qualified as his IME on 28 July 2016 and who provided a report dated 4 August 2016.

108. A/P Robertson took a history in which he noted:

> "Throughout the course of his work as an ambulance officer and subsequently as a paramedic, Mr Cooper had a significant exposure to traumatic stress, including attending fatal motor vehicle accidents, the aftermath of suicides and homicides, dealing with aggrieved relatives of gravely ill or deceased patients, dealing with very disturbed psychiatric patients and particular emotional interactions during coroner's inquests."

109. Assoc/Professor Roberson recorded:

> "Mr Cooper first noted psychiatric symptoms in 2010, which emerged gradually. He recalls that he would isolate socially, become irritable with reduced sleep, emotional liability and impaired concentration and short-term memory. He also recognised that his work performance declined.

110. Assoc/Professor Robertson records a history relating to Mr Cooper's consumption of alcohol which was consistent with the other evidence in the case. He noted that

> "Mr Cooper had drunk what he regarded as a "normal" volume of alcohol, however by 2010 his use of alcohol had escalated to the point where he was drinking in excess of 12 standard drink a per day usually wine. He became physically dependent on alcohol and would drink to avoid withdrawal. He made repeated attempts to cut down his use of alcohol and would often become angered when confronted by his alcohol use. He also felt at times quite guilty about his drinking. He demonstrated derange liver test and became hypertensive. He also suffered from chronic diarrhoea."

111. Assoc/Professor Robertson takes the history of the marriage breakdown as well as the events that evolved at work in terms of alcohol misuse and taking sick days, the refusal of the breath test and the misconduct proceedings.

112. The history that Assoc/Professor Robertson has about Mr Cooper's escalating use of alcohol from 2010 is largely consistent with the other evidence that is before me.

113. Assoc/Professor Robertson conducted a mental state examination of which he recorded his findings as follows:

> "Mr Cooper attended the interview alone.
>
> He was casually attired. He had a ruddy face, palmar erythema and seemed to be carrying excess weight.
>
> He was quite tremulous and seemed amidst the early stages of alcohol withdrawal although claims that he had a beer before coming.
> His affect was labile, his mood was dysphoric. There were no signs of psychosis or dissociation. He denied being suicidal.
>
> He provided a fluent history."

114. Assoc/Professor Robertson notes that he had before him:

> "I note correspondence from the Ambulance Service pertaining to the disciplinary management of his drinking problem. There are two fitness for duties assessments completed by Dr Abeya, diagnosing alcohol dependence and an adjustment disorder with depressed mood as well as noting his cardiac difficulties. Certificates of capacity list a provisional diagnosis of post traumatic disorder."

115. In other words, Assoc/Professor Robertson has the benefit of all material pertaining to the disciplinary process and why it arose.

116. Assoc/Professor Robertson assessed Mr Cooper as follows:

> "Mr Cooper is a 52 year old former paramedic, who presents with clear evidence of alcohol dependence.
>
> There appears to be underlying co-morbid psychiatric morbidities. He has some features of PTSD, other features if phobic anxiety as well as depression. Many of these symptoms are explicable in terms of his chronic consumption of alcohol and its neurotoxic effects. He is also demonstrating significant medical co-morbidities arising from his alcohol use.
>
> He was treated for situationally driven depression in 2002 which bears no relevance to his current presentation.
>
> In the course of his employment with the Ambulance Service Mr Cooper was subject to cumulative exposure to traumatic stress, which in my view was the primary determinant to his alcohol use. His drinking behaviours prior to his entry in service with the ambulance service was within normal community levels and his drinking behaviours escalated to the point of alcohol dependence by 2010.
>
> Diagnostically the most appropriate formulation would be the primary diagnosis of a substance use disorder (alcohol dependence) with "cross cutting features of PTSD". The latter condition is either masked by alcohol dependence or sub-clinically present."

117. Assoc/Professor Robertson has a history that broadly accords with the other evidence in the case and he considers that the primary determinant of Mr Cooper's alcohol use was the cumulative exposure to traumatic stress

118. Assoc/Professor Robertson is asked "Whether Mr Cooper's psychological injury has been contributed to by non-work-related matters. f so how?." He answers:

> "I could not identify any competing factors. Much of the psychosocial adversity Mr Cooper describes are consequences of his drinking behaviour."

119. When Assoc/Professor Robertson is answering a series of specific questions at the end of his report, he answers in respect to diagnosis as follows:

> "Mr Cooper presented with alcohol dependence with cross-cutting features of PTSD. He has a number of significant medical co-morbidities."

He is asked:

> "Your opinion as to whether Mr Cooper's psychological injury, if any, has been substantially contributed to by his employment with the NSW Ambulance Service? And he answers:
>
> "My view is that Mr Cooper's alcohol dependence emerged in the course of his duties as a paramedic".

120. Counsel for the Ambulance Service submitted:

> "So he's saying that if there are some features it doesn't constitute a diagnosis of PTSD and that is consistent with Dr Abeya and the latter condition is sub-clinical. In other words, it's not sufficient for a diagnosis. He makes an assessment of the applicant's permanent impairment and he says in paragraph 4 at page 19:
>
> "In my view his alcohol dependence emerged in the course of his duties as a paramedic."
>
> He's not specific in relation to what duties those were."

121. This submission ignores that Assoc/Professor Robertson has clearly identified earlier in the report that:

> "In the course of his employment with the Ambulance Service Mr Cooper was subject to cumulative exposure to traumatic stress, which in my view was the primary determinant to his alcohol use."

122. This is the duties that he is clearly referring to, namely that Mr Cooper's duties subjected him "to cumulative exposure to traumatic stress". I have referred extensively to Mr Cooper's evidence of the traumatic stress that he was exposed to over time.

123. Counsel for the Ambulance Service said that Assoc/Professor Robertson didn't reach a diagnosis of PTSD. Assoc/Professor Robertson clearly diagnosed that there were cross cutting features of PTSD in Mr Cooper's clinical presentation. Assoc/Professor Robertson very clearly diagnoses psychological injury (alcohol dependence with cross-cutting features of PTSD) arising out of or the course of Mr Cooper's employment with the Ambulance Service, namely as the result of Mr Cooper's cumulative exposure to traumatic stress.

124. I note that Assoc/Professor Robertson's opinion that Mr Cooper has suffered a psychological injury as a result of his employment with the Ambulance Service is consistent with the opinion of Dr Potter, psychiatrist, to whom the insurer had referred Mr Cooper in September 2015.

125. The insurer referred Mr Cooper to Dr Brian Potter, Consultant Psychiatrist as their IME. Dr Potter saw Mr Cooper on 2 September 2015 and provided a report dated 16 September 2015.

126. I note that Dr Potter had before him the reports of Dr Abeya dated 7 November 2014 and 24 February 2015.

127. Dr Potter took a history largely consistent with the other evidence. Dr Potter noted that the history evolved with ongoing enquiry throughout the assessment process.

128. Dr Potter noted that Mr Cooper had not been aware of any impact of his exposure to traumatic events as follows:

> "He explained that he had not been aware of any impact of his exposure to traumatic events, although described 'Slowly surely isolate myself. Stopped football, surfing, the club'. He became reclusive and had a lot of anger issues, as well as abusing alcohol. Most of his problems were caused through social isolation, 'anger at the world and problems with family and friends and eventually my relationship'".

129. Dr Potter recorded noted the "Psychological impact of work experience":

> "To the ongoing enquiry he gave vague generalised comments about his experience of exposure to trauma as if wishing to avoid knowing or thinking about them."

130. This is Dr Potter clinical assessment when eliciting a history of exposure to trauma, namely "Mr Cooper relates his history in manner that suggest he wants to avoid knowing or thinking about the traumatic events."

131. Dr Potter bring his clinical experience into play when eliciting this history and assessing Mr Cooper's mental state on relay of the history.

132. Dr Potter goes on:

> "When asked about the impact on him, he described 'very bad nightmares. Strange ones graphic and bizarre dreams. Amputating woman's legs, car accidents with bodies everywhere'.
>
> He gave a frequency of a couple of times a week. Also, a couple of times a week he will wake in a cold sweat, adding "a little shaken*".*
>
> Ms Dawe echoed: "A couple a week".
>
> Mr Cooper then added spontaneously that he" nearly hit Cassandra [Ms Dawe] the other night, within disturbed sleep.
>
> He gave a timeframe of *'*close on two years'.
>
> At the time he had not considered post-traumatic stress disorder and his psychologist recommended that he receive treatment for it.
>
> When asked about memories of flashback of traumatic events during the day, he described an actual event, with confused information and the recent storms in the Newcastle area, all of which he found, 'very scary'.
>
> When asked if there is now a need to avoid reminders of his traumatic past, he advised that there is not much he can avoid because of the diversity of the incidents to which he has attended. He advised, 'Doesn't stop me, but do think about.'
>
> Ms Dawe offered 'Goes into his own world'".

133. At the time he saw Dr Potter, Mr Cooper was not drinking alcohol as he was involved at that time in a 12 week lifestyle program at the hospital which had the expectation of no alcohol. Consistent with Mr Cooper's evidence, Dr Potter records the escalation in alcohol use from about 2010. Dr Potter records:

> "He gave a previous intake of alcohol of six to ten standard drinks a day. He gave the timeframe as probably from 2010, a year or two prior to his marriage breakup.
> Prior to that, he described he had always enjoyed a beer, 'A beer or glass of wine most days, except when on call'.
>
> To further enquiry, he offered, 'On the weekend maybe a couple more'."

134. Dr Potter recorded his findings on mental state examination as follows:

> "He was neatly dressed and groomed, he was dressed in Ambulance branded working overalls. He was tall to medium height of solid build and would be considered medically significantly overweight.
>
> He related in an apprehensive and avoidant manner as if wishing to maintain and control his emotional function.
>
> His affect did not necessarily reflect the content of the history being provided. He fluctuated from a serious effect to a jocular affect, again in a manner which suggested a need to contain the stress.
>
> There was no evidence of a psychotic illness or brain syndrome;
>
> He appeared to have average intelligence.
>
> Mr Cooper behaved in a manner consistent with an individual wishing to not know about his recent traumatic and disturbed history, dealing with the knowledge of these events through denial, complemented by the excessive use of alcohol."

135. A psychiatrist brings his clinical skills, judgement and experience to bear when assessing the mental state of a person. Dr Potter has done this and noted the significant feature of Mr Cooper behaving in a manner that represents an avoidance of the trauma to which he has been exposed. Dr Potter considers he displays avoidance strategies (his affect fluctuates between jocular and serious and does not appropriately reflect content, he is vague) when relaying the history of the traumatic events and this attempt at denial is also reflected in his excessive use of alcohol.

136. Dr Potter makes the following diagnosis:

> "Mr Cooper is a poor historian. With personality traits with emotional underdevelopment he deals with trauma and adversity through denial i.e. wishing to not know about it. This is complemented by his use of alcohol. He also has an expectation that he will be cared for and looked after.
>
> Reflecting the above, it is clinically difficult to obtain a clear history of his experiences and functioning.
>
> Allowing for this, there is a theme of having been traumatised by his work, which has significantly interfered with his behaviour and function and with which he turned to an increased use of alcohol, as is also demonstrated with the difficulties with his previous business.

With the background of vulnerable emotional functioning and wishing to cope by denial with trauma, there is a consistent theme in Mr Cooper's history and presentation, of the diagnosis detailed in the American Psychiatric association Diagnostic manual, the DSM of:

- Chronic post-traumatic stress disorder and
- Co-morbid substance (alcohol) abuse".

'

137. I note that Dr Potter, IME for the insurer diagnosis that Mr Cooper's suffers from PTSD which is chronic is consistent with that of his treating psychiatrist Dr Wade.

138. Under "Summary and Discussion", Dr Potter sets out:

> "Mr Cooper is a 51 year old ambulance officer. He is separated from his wife of 18 years in 2012 and has two teenage children, both of whom are students. The elder continues to live with Mr Cooper and attends university. He was born in a country town in England, coming to Australia at about the age of four for a better family life."
>
> As detailed under the heading of "diagnosis above, within a difficult history and presentation, he does present with features of a chronic post-traumatic stress disorder and co-morbid alcohol abuse. He appears to have received and is receiving reasonable and appropriate treatment.
>
> His prognosis is guarded. Although he wishes to return to ambulance work, quoting financial reasons, in accepting a chronic post-traumatic stress disorder related to his traumatic ambulance work, it will be clinically inappropriate for him to undertake any work which constantly remind him of his exposure to human morbidity and mortality."

139. The insurer asked Dr Potter a series of questions which he answered as follows:

> "1. Does Mr Cooper have a DSM-IV diagnosis?
>
> Mr Cooper's history and presentation is consistent with the DSM diagnosis of a chronic post-traumatic stress disorder and co morbid alcohol abuse, as detailed under diagnosis above.
>
> 2. does Mr Cooper have a psychiatric disorder or is he simply describing emotional distress that has developed secondary to his performance management?
>
> Although a difficult historian, it is clinically reasonable to accept the psychiatric diagnosis as referred to in question 1.
>
> 3 Is Mr Cooper's employment with the NSW ambulance a significant contributing factor to his current diagnosis?
>
> In accepting chronic post-traumatic stress disorder from his exposure to the trauma of ambulance work, it is reasonable to accept this connection.
>
> He has a background emotional underdevelopment which however has required exposure to significant trauma to lead to the development of a chronic anxiety disorder.
>
> 4. Is there a pre-existing psychiatric condition? Has work aggravated this pre-existing condition and if so, when is it likely to cease?"
>
> He gave no history of a pre-existing psychiatric condition, to be aggravated by his work, with the collapse of his business in 2006, with the significant stress of the loss of his business, he responded with brief, treated psychiatric disturbance. This can be seen as a separate diagnosis."

> What is the probability that the injury or similar injury would have occurred anyway at about the same or at the same stage of the worker's life, if he had not been at work or not worked in that employment.
>
> At any time in Mr Cooper's life, exposure to significant life stress is likely to have resulted in a clinically significant disorder.
>
> Were non work factors significant in the initial development of the psychiatric condition? Is alcohol abuse materially significant in the injured workers presentation?
>
> Possible non work factors such as the separation from his wife and alcohol can be seen as expression of his underlying developing chronic anxiety disorder with depressive features, a chronic post-traumatic stress disorder.
>
> Has alcohol abuse materially contributed to the development of the injured workers condition or employment difficulties or did it appear after the onset of these issues?
>
> It is likely that he used the alcohol to help his self-contain his anxiety and disturbance which unfortunately is likely to also contribute to the depressive features."

140. In other words, the issue of Mr Cooper's alcohol abuse being non work related is squarely put to Dr Potter and he very clearly considers the alcohol abuse to be an expression of Mr Cooper's PTSD which he considers chronic. He considers, upon the history taken and consistent with his findings on clinical assessment, that Mr Cooper used alcohol as a means of dealing with his anxiety and distress from exposure to the significant trauma in the course of his duties, that is, as a tool for denial or avoidance.

141. Dr Smith, consultant clinical and forensic psychiatrist saw Mr Cooper at the insurer's request on 22 September 2016 and Dr Smith provided a report of the same date and a supplementary report dated 2 November 2016 in which he expresses a completely different view to that of Dr Potter.

142. Dr Smith doesn't diagnose PTSD but his diagnosis is limited to severe alcohol use Disorder which he considers existed since at least 2002 and is unrelated to his employment.

143. Dr Smith took a history that is broadly consistent with the other evidence that is before me. Counsel for the ambulance service notes that Dr Smith had a more florid history of Mr Cooper's problems with alcohol prior to joining the ambulance service. The difference in history seems to be that Dr Smith recorded a history that in 2002, around the time of the collapse of his business, Mr Cooper was charged with high range PCA. No conviction was recorded.

144. He notes that Mr Cooper recognised that for many years he used alcohol as a coping mechanism.

145. He noted the exposure to many distressing situations throughout the course of employment as paramedic. He reported the particularly distressing incident in 2007 with the death of the eight month old baby.

146. He noted that "Mr Cooper stated that the most distressing incidents were deaths of children particularly as he had young children at the time himself. He stated that he had attended "a large number, approximately 6 to 12, "…of incidents involving deceased children. The death of the eight-year girl (Jasmine Kite) is recorded as particularly distressing.

147. Dr Smith notes:

> "Mr Cooper stated that notwithstanding the distress associated with these incidents he had always considered that he coped reasonably well with them. He acknowledged that he had continued to utilise alcohol as a coping mechanism after commencing employment as a paramedic".

148. Dr Smith records the history of an escalation in alcohol consumption by 2010.

149. Dr Smith conducted a mental state examination

150. He reviewed the documentation which included the reports of Dr Abeya, Dr Potter and Assoc/Professor Robertson.

151. Dr Smith diagnosis, which he describes as a provisional diagnosis, is Alcohol Use Disorder, Severe made according to DSM-5.

152. Dr Smith provides the following justification for his diagnosis:

> "Mr Cooper described a history of problematic alcohol consumption from at least 2002 at which time he was charged with high range PCA after using alcohol to cope with distress in the context of the liquidation of his business. He reported an escalation in alcohol consumption to heavy, daily alcohol use by 2010 and this had continued to the present time despite numerous consequences including the loss of his marriage, drinking at work, disciplinary problems associated with being intoxicated ta work, medical problems and severe withdrawal symptoms and an overdose whilst intoxicated.
>
> He reported ongoing heavy daily alcohol consumption associated with tolerance, withdrawal symptoms, difficulty controlling consumption, ongoing alcohol consumptions despite numerous complications (including worsening of mood, relationship conflict, employment disciplinary issues and legal issues) and relapses to alcohol consumption despite treatment in a detoxification facility (criterion A)."

153. Dr Smith considered the "differential diagnosis" as follows:

> "Mr Cooper did not describe current symptoms consistent with an alcohol induced depressive disorder. He reported a history of anxiety, panic attacks and depressive symptoms in 2002 around the time of his high range PCA charge. On the basis of the provided history, it was not possible to determine if those symptoms represented an episode of discrete mood disorder, alcohol induced depressive disorder or an adjustment disorder.
>
> Mr Cooper described exposure to significant traumatic events during his employment as a paramedic. His current symptoms are best explained by his severe Alcohol Use disorder. He reported marked anxiety in alcohol withdrawal and sleep disturbance characteristic of alcohol use Disorder. He did not describe recurrent flashbacks or intrusive memories. He reported memories when passing places associated with traumatic events. In the presence of his ongoing pattern of heavy, daily alcohol consumption it is not possible to diagnose PTDS as the majority of his reported symptoms are consistent with his severe alcohol use disorder. He requires an extended period of abstinence to assess the nature of any ongoing anxiety symptoms that might be consistent with PTSD."

154. Dr Smith summarises his opinion as follows:

"On the basis of the available documentation, his reported history and presentation, the only diagnosis that can confidently be made is that of severe alcohol use disorder, Mr Cooper described his problematic alcohol consummation from at least 2002, when he was charged with a high range PCA offence and escalation to heavy daily alcohol consumptions from at least 2010. In my opinion, given his reported long standing pattern of using alcohol to cope with anxiety and distress, with evidence that this pattern was established as early as 2002, it is not possible to find that his problematic alcohol consummation developed as "self-medication" for distress associated with his employment with the NSW ambulance service.

Although he had been diagnosed with PTSD the majority of his symptoms were consistent with severe alcohol use disorder. In my opinion Mr Cooper requires a lengthy period of abstinence (of at least six months to determine if he does in fact suffer from persistent anxiety after cessation from alcohol."

155. In his supplementary report dated 24 November 2016 Dr Smith opines that Mr Cooper's employment with the ambulance service did not aggravate, accelerate or exacerbate his pre-existing condition of Alcohol Use Disorder on the basis that:

"Alcohol Use Disorder is a condition associated with chronic, relapsing and progressively deteriorating course. In Mr Cooper's case there was evidence (from his history and available documentation) that he developed this condition prior to the commencement of his employment as a paramedic in 2005. The natural history of this condition is for gradually progressive deterioration and this has been demonstrated in in his case. In my opinion his employment as a paramedic did not serve to aggravate, accelerate or exacerbate this condition, his condition would have, on the balance of probabilities, deteriorated in the same way if he had not been employed as a paramedic.

156. When weighing Dr Smith's opinion in the balance with the other evidence, I take into account the following:

- Dr Smith diagnoses that Mr Cooper had a pre-existing condition of alcohol use disorder from about 2002 or dating from the collapse of his business. This is despite there being no medical evidence that diagnoses such a condition contemporaneous to 2002. Mr Cooper's evidence is that he was diagnosed, at that time of the collapse of his business in 2002, with a depressive disorder for which he received medical treatment and which resolved. There is no evidence to contradict this statement and he was not cross-examined. The fact that he was charged with a high range PCA in 2002 does not prove he had an alcohol use disorder at that time, particularly in the absence of any contemporaneous medical evidence to that effect. The available evidence suggests that his depressive condition diagnosed in 2002 fully resolved with treatment at the time – it took about 6 months. He was able to obtain new full-time employment as a lifeguard and then in 2005 obtained employment on a fulltime basis with the Ambulance Service. He was able to work in that employment without coming to adverse attention until at least 2012/2013 which led to a referral to assess fitness for employment to Dr Kong in October 2014 and Dr Abeya in November 2014 on the background of poor work attendance and issues related to the use of alcohol.

- The consistent history given to all the doctors that from 2010 there was an escalation to heavily daily alcohol consumption. Mr Cooper gave evidence that this dated from the death of eight-year-old Jasmine Kite in 2010 and he was not cross-examined about this.

- Dr Smith notes that Mr Cooper has always used alcohol as a coping mechanism when faced with distress and anxiety. He takes a history of the "exposure to significant traumatic events during the course of his employment as a paramedic" including the death of babies, young children and teenagers and contact with their grief stricken

parents in the context of Mr Cooper having young children of his own which Mr Cooper describes as making it all the more distressing for him. Notwithstanding this history and his acknowledgement that he uses alcohol to cope with distress and anxiety, Dr Smith ruled out categorically that this exposure to trauma could have aggravated, accelerated or exacerbated what Dr Smith describes as pre-existing Alcohol Use Disorder.

- Dr Smith identifies symptoms that Mr Cooper reports to him which are consistent with PTSD but says that it is not possible to diagnose Mr Cooper as having PTSD by the time he sees him on 22 September 2016 because of the severity of the Alcohol Use Disorder.

- Dr Smith is the only doctor whose reports are in evidence not to diagnose a PTSD or other anxiety or depressive disorder concurrent with the Alcohol Use disorder. Even Dr Abeya considered in November 2014 that he had an adjustment disorder (although she did not attribute this to his employment) and by her report in January 2016 considered that he had PTSD-like symptoms as a result of his employment.

157. Counsel for the Ambulance Service addressed me on Dr Abeya's reports which are dated November 2014, 24 February 2015 and 22 January 2016. She submitted that I would find the evidence of Dr Abeya the most persuasive because it was the most contemporaneous. She submitted, referring to Assoc/Professor Robertson's opinion and Dr Abeya's opinion:

> "So he's (Assoc/Professor Robertson) saying that if there are some features it doesn't constitute a diagnosis of PTSD and that is consistent with Dr Abeya and the latter condition is sub-clinical. In other words, it's not sufficient for a diagnosis. He makes an assessment of the applicant's permanent impairment and he says in paragraph 4 at page 19:
>
> 'In my view his alcohol dependence emerged in the course of his duties as a paramedic."
>
> He's not specific in relation to what duties those were. In paragraph 5 he makes the assessment of the whole person impairment and at page 20, paragraph 7:
>
> 'I could not identify any competing factors. Much of his psychosocial adversity Mr Cooper describes are consequential of his drinking behaviour.'
>
> So the doctor makes his assessment accordingly based on the applicant's chronic alcohol problems and on the basis of that the applicant brings his claim. Now, there are - given the contemporaneous nature of Dr Abeya's reports, it would be my submission that she is the most persuasive in terms of the applicant's condition."

158. Dr Abeya takes a history that is broadly consistent with the other evidence. In her first report in November 2014 Dr Abeya does not take a detailed history of the trauma to which Mr Cooper was exposed. This may be because Mr Cooper downplayed the effect it had on him and was focussed on what he perceived as his poor treatment by the Ambulance Service. As well, at that time, there had been no diagnosis by any treating professional that Mr Cooper suffered from PTSD. Nonetheless there was no analysis by Dr Abeya of whether Mr Cooper may be engaging in avoidance strategies to contain the effect that his exposure to trauma had on him which is the conclusion Dr Potter came to. Mr Cooper has given evidence and his history to Dr Potter is consistent with this, namely he didn't know that what he was going through was PTSD until his psychologist Ms Erlich told him that.

159. Dr Abeya considered him temporarily unfit for his work as a paramedic. She said:

> "From a psychiatric point of view Mr Cooper is currently temporarily unfit. I would allow for a further period of six months of treatment prior to review to consider his capacity to

resume work as an operational paramedic, his illness conditions are alcohol dependence and adjustment disorder. He does not satisfy the above definitions (of PPD or TPD) as there remains for room for improvement."

160. Dr Abeya saw him again on 24 February 2015 and provided a report of the same date. She summaries the findings of her November 2014 report as follows:

> "Mr Cooper is a 51-year-old paramedic who has been on alternate duties since the latter part of 2014. I initially assessed him in November 2014 in the background of poor work attendance and issues related to his use of alcohol, He was also assessed by Dr Dale Kong (senior occupation physician) in October 2014 and found to be fit for his role. When I last assessed Mr Cooper I was of the view that he had significant alcohol use issues which I felt could be classified as alcohol dependence, in addition he had evidence of depressive symptoms which could be classed as an adjustment disorder with depressive symptoms.
>
> In terms of the background history, whilst he had longer term alcohol use, his excessive use appeared to have been over the two years prior to the last assessment whilst his depressive symptoms appear to have been over the one and half years prior to the assessment. Amongst the different stressors which appear to have led to these issues are his relationship problems."

161. Again Dr Abeya has focused on problems such as relationship stressors without adequate consideration, given the other evidence that is before me, of the effect on Mr Cooper's psychological state of the exposure to significant trauma on a cumulative basis. I note that in this regard Assoc/Professor Robertson and Dr Potter both identify the problems such as the relationship breakdown as being a revelation or expression of Mr Cooper's psychological injury as opposed to being a cause.

162. Dr Abeya notes that since he was last assessed:

> "Mr Cooper appears to have made progress in trying to overcome his alcohol dependence to some degree. He appears to have managed a reasonable degree of sobriety over the past 3 months, but I feel may still have a pattern of some use though not excessive. His assertion that, save for three occasions, he has been entirely abstinent, but I feel it is likely to been more – yet not during the week. It would appear that this has been largely due to his own resistance but he has had assistance from his GP and his psychologist. In addition his mood state has improved significantly and he presented with a normal state of mood today. This would certainly have assisted in limiting his use of alcohol as his use appears to have been a maladaptive method of coping with difficult thoughts."

163. On 22 January 2016, the Ambulance Service referred Mr Cooper again to Dr Abeya who provided a report dared 22 January 2016. The purpose of the referral was to request an Independent Clinical Assessment for Mr Cooper for the purposes of determining his fitness to engage in the inherent duties of his substantive role as a paramedic.

164. Dr Abeya noted that she had previous file notes, her previous reports, and the history and documents relating to the disciplinary process that Mr Cooper had undergone. She also was given by Dr Maher (the GP) a report from Dr Potter dated 16 September 2015.

165. Dr Abeya noted she had the opportunity to speak to Dr Maher as well as a representative from the Ambulance Service.

166. Dr Abeya noted the main reasons for the referral provided in the letter of referral are described below:

> "By way of background it was noted Mr Cooper has a history of alcohol dependence and was assessed by myself on 7 November 2014 when I made him temporarily unfit for full duties but fit for alternate duties whilst he had further treatment for alcohol use and adjustment disorder. On 24 February 2015 he was again assessed by myself when he was made fit for full operational duties under a remedial plan which included random breath testing. On 17 March 2015 he had entered RTW plan, on 17 May 2015 he was required to undergo a breath test for alcohol but had refused believing he would test positive as he was required to give a zero reading. He was stood down while the matter was assessed. On 22 May 2015 he was allowed to return to work on alternate duties under the same RTW plan he previously had. On 12 June 21015 the chief executive had made a decision to deal with the matter as misconduct indicating dismissal would be the most severe penalty and as Mr Cooper elected to meet with the chief executive before a final decision a meeting as scheduled for 8 July.
>
> On 2 July 2015 Mr Cooper had allegedly taken an overdose of Valium (10 tablets) and had consumed an excessive amount of alcohol (registered at .21) at home and was transferred to hospital. He was released from hospital on 5 July and had reportedly said to his manager "what do I have to do to get attention, kill myself?" On 11 August 2015 the disciplinary process was suspended as per Dr Maher's (treating GP) advice. On 28 September whilst performing alternate duties at Hamilton Mr Cooper had supplied a positive breath test with an initial reading of 0.036 and was stood down from duties. Disciplinary processes were recommenced after that. Mr Cooper had composed a written submission in this regard. Concurrent to this process it was noted that Mr Cooper had submitted a work-related injury for PTSD and that the claim had been accepted by QBE. It was noted that he had been examined during this claim by Dr Brain Potter (psychiatrist) who advised it would be 'clinically inappropriate for Mr Cooper to return to duties as an operational paramedic where he would be constantly reminded of his exposure to human morbidity and mortality'."

167. Dr Abeya reviewed the history and Mr Cooper's presentation. She conducted a mental state examination of Mr Cooper.

168. Dr Abeya comes to the view that Mr Cooper appeared to have some symptoms of PTSD. She notes her findings in this regard as follows:

> "During todays' assessment Mr Cooper also revealed that he felt he had longer term anxiety issues and mood swings along with what he reported was depression, social isolation and substance use. He believed these were related to what he had been informed was a PTSD. On specific questioning today Mr Cooper appeared to have some symptoms of a possible PTSD in terms of his reaction to triggers/reminders of past situation and the negative changes in his emotions and thoughts as well as a wish to avoid certain situations (though he does not actually do this). Given his history and presentation despite this I remain unconvinced that he has a diagnosable full PTSD as per the DSM-5 guidelines. I find there have been inconsistencies in his reporting and am therefore unsure of what is true and what is not. In addition his description of possible PTSD symptoms were again not entirely convincing. I note I later had access to the report by Dr Brian Potter, independent psychiatrist (for the insurer) – whilst he had suggested chronic PTSD he mentioned that he found it clinically difficult to obtain a clear history. It is likely though that he may have a subsyndromal possibility of PTSD in deference to what he described today. I refer to the 'Expert Guidelines for the diagnosis and treatment of PTSD in emergency service workers' in this regard."

169. I note that those Guidelines referred to by Dr Abeya provide in respect of subsyndromal symptoms of PTSD as follows:

> "A further complexity amongst emergency workers us the issue of subsyndromal symptoms. Subsyndromal symptoms occur when an emergency worker has symptoms

consistent with PTSD, but where the intensity or combination of symptoms are not sufficient for PTSD to be diagnosed. A Number of cross-sectional and longitudinal studies have suggested that subsyndromal PTSD is relatively common amongst emergency workers. Once subsyndromal symptoms are present, they can become chronic and associated with significant impairment. Studies of emergency workers have shown that early or prolonged subsyndromal symptoms increase the risk of future mental health problems, such as PTSD. Subsyndromal PTSD symptoms have also been assonated with higher levels of co-morbid depression, increased level of suicidal ideation, greater anger and hostility and more sickness absence. There is increasing awareness of the importance of early recognition and early intervention within Psychiatry. As such, individuals with subsyndromal symptoms of PTSD or early signs of Acute Stress Disorder (ACD) are increasingly being considered as candidates for proactive early intervention. While a detailed discussion of these pre-diagnosis interventions are outside the scope of these Guidelines, it is important to recognise that subsyndromal symptoms are particularly relevant for emergency service workers exposed to multiple traumatic incidents."

170. Dr Abeya went onto say:

> "Given the current presentation of his ongoing alcohol use disorder and the possible subsyndromal PTSD like symptoms, I find Mr Cooper unfit for his substantive role as a paramedic. Indeed, his current presentation would make him unfit for any form of work at present until he has further treatment for his alcohol use and more control in this regard. It is difficult to predict the outcome of the subsyndromal PTSD symptoms without a clear history and without appropriate treatment and without also controlling his alcohol use. I would strongly advise review by a treating psychiatrist for further diagnostic clarification and an appropriate treatment plan.
> Yet it's necessarily to keep in mind that there could certainly be an exacerbation or worsening of such symptoms if faced with significant stress at work. It would probably therefore be necessary to consider returning Mr Cooper to non-operational duties at the point that he is ready to consider a return to work. It may well be another six months to a year then prior to Mr Cooper being in a fit state to reconsider a return to his substantive position. I note that this would only be possible if he has a specific treatment and support for his symptoms. It is clear that considering any immediate return to his work as a paramedic would pose a risk both to Mr Cooper (of exacerbation of his PTSD like symptoms) and to other (if he were in an intoxicated state)."

171. In other words, by her report in January 2016 Dr Abeya as counsel for the Ambulance Service said, "concedes" the presence of subsyndromal PTSD symptoms. Counsel for the ambulance service suggested that this falls short of a PTSD diagnosis and the submission seems to be that I couldn't therefore find that Mr Cooper had suffered a psychological injury as a result of his exposure to multiple traumatic incidents. However, the expert guidelines to which Dr Abeya herself refers, make it clear that the subsyndromal symptoms are still a psychological condition and would be sufficient for me to find that Mr Cooper has suffered psychological injury in the course of his employment by reason of exposure to multiple traumatic incidents. Of course Dr Potter and Dr Wade consider that Mr Cooper has chronic PTSD and A?P Robertson considers that there are cross-cutting features of PTSD. As I said before Dr Smith is the only expert who does not find there to be symptoms of PTSD.

172. Counsel for the Ambulance Service submitted:

> "The diagnosis, as I've said, is that of alcohol abuse and without some sort of contemporaneous evidence recorded that that alcohol abuse was contributed to or aggravated by the applicant's employment in terms of the traumatic events.
>
> It's my submission that on balance, on the histories provided to Dr Robertson,

> Dr Abeya and Dr Smith all record the real cause for the applicant's problem is a developing alcohol abuse and there is nothing contemporaneous to support the link between the alcohol abuse and any of the traumatic incidences.
>
> The only complaint really that the applicant made prior to initiating a claim in June 2015 when his employment was finished - I withdraw that. Prior to the applicant's employment being terminated his own real complaint was in respect of work issues evolving out of the discipline process rather than the traumatic events that he now alludes to in terms of causative factors."

173. I am not persuaded by the submissions of counsel in this regard.

174. Mr Cooper doesn't have to have made a complaint about the exposure to trauma affecting him mentally prior to him leaving work in June 2015 for me to find that he has suffered a psychological injury. Any such finding depends on the facts and circumstances of each case and weighing the medical opinion in the balance in order to make a determination as to injury on the balance of probabilities. Mr Cooper gave evidence in his statement about why he didn't complain, namely his perception of the culture of the Ambulance Serve was that you just carried on. He was not cross-examined about this evidence. Moreover, a person can develop a psychological condition without any self-awareness about its development. He told various doctors that he didn't have any self-awareness of why he was reacting the way he was until he was told by his psychologist Ms Erlich that he had PTSD. It is not for a lay person to diagnose his own mental condition, that is a matter for expert opinion. I have to weigh in the balance all of the evidence, including the various expert opinions, and determine on the balance of probabilities whether Mr Cooper suffered a psychological injury in the course of or arising out of his employment with the Ambulance Service.

175. When I weigh all of the evidence in the balance and taking into account the evidence of Mr Cooper of the significant and multiple traumatic incidents to which he was exposed over time and his evidence of the effect that this had upon him about which he was not cross-examined, I prefer the evidence, for the reasons explained throughout, of the treating psychiatrist Dr Wade, supported by Dr Potter, and Assoc/Professor Robertson and ultimately by Dr Abeya (who found subsyndromal, or PTSD, like symptoms) that Mr Cooper suffered a psychological injury ' in the course of or arising out of his employment, to which his employment was a substantial contributing factor'.

176. If it is necessary for me to find the nature of the injury, then I am satisfied on the evidence that Mr Cooper's psychological injury consists in the form of PTSD and Alcohol Use Disorder.

177. If these conditions constituting psychological injury are more properly considered diseases, then I am satisfied on the balance of probabilities that Mr Cooper's employment which involved him in the cumulative exposure to significant traumatic incidents was the main contributing factor to the contraction of the diseases.

178. I have been satisfied on the balance of probabilities that Mr Cooper suffered a psychological injury in the course of or arising out of his employment as a paramedic because of cumulative exposure to traumatic events.

179. This submission that a section 11A defence is available in this case simply cannot be supported. Section 11 A provides that Mr Cooper could not recover compensation for his psychological injury if it was wholly or predominantly caused by reasonable action taken by the Ambulance Service in relation to discipline or performance appraisal (being the two heads of section 11A upon which the Ambulance Service relied in their section 74 notice).

180. Here all of the doctors whose reports are in evidence have a history that Mr Cooper was subject to a disciplinary or a performance process. Not one of them opines that Mr Cooper's psychological injury results from the reasonable action of the employer taken or proposed to

be taken in relation to performance appraisal or discipline. There is simply no medical opinion that supports an 11A defence and it must fail.

181. Given this is a claim for lump sum compensation only, the matter will be referred to the Registrar for referral to an Approved Medical Specialist (AMS) to assess the degree of permanent impairment, if any, as a result of psychological injury deemed to occur on 17 March 2015.

182. This was the date of injury “pleaded” in the Application. There were no submissions made in respect of the date of injury and no submissions made on behalf of the Ambulance Service that the pleaded date was incorrect. Accordingly, since Mr Cooper has been successful on the finding of injury, I will adopt the pleaded date in the absence of submissions to the contrary.

183. The documents to be referred to the AMS are those which were admitted into evidence by consent.