WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **4751/17**
Applicant: **Gregory Cooper**
Respondent: **State of New South Wales (NSW Police Force)**
Date of Determination: **18 April 2018**
Citation: **[2018] NSWWCC 100**

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 6 May 2017.

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 attached documents with the exception of the reports of Dr Vickery and Professor Robinson which are not relied upon by the Applicant.

    (b) Late Documents filed by the Applicant with an Application to Admit Late Documents dated 17 October 2017.

    (c) From the late documents filed 13 February 2018, the Applicant relied only upon a questionare dated 7 December 2015 adressed to TMF which has been removed from the bundle of late documents and marked exhibit “A”.

    (d) Reply and all attached documents with the exception of the report of Dr Vickery upon which the Respondent elects not to rely except as to history.

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
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. By Application to Resolve a Dispute (the Application) filed 21 March 2017, the applicant, Mr Gregory Cooper (Mr Cooper) seeks lump sum compensation as a result of psychological injury alleged deemed to occur on 6 May 2017.

2. The respondent is the State of New South Wales, Mr Cooper having been employed as a police officer with the Police Force of New South Wales (the Police).

ISSUES FOR DETERMINATION

3. Mr Cooper alleges that he suffered a psychological injury/Post-Traumatic Stress Disorder (PTSD) deemed to occur on 6 May 2017.

4. In summary, Mr Cooper alleges that his psychological injury is based upon his exposure to trauma throughout his employment with the Police from 1997, including the traumatic event on 18 March 2012 when a Brazilian tourist died in police custody during an arrest when Mr Cooper was the commanding officer (death in custody) and the sequalae that followed that event including the coroner's inquest, adverse media attention and the manner in which he perceived he was treated by his employer and fellow police officers.

5. As per the section 74 notice dated 21 July 2017 the Police accepted Mr Cooper's "psychological injury was caused by the events of 18 March 2012 and subsequent perceived disgrace".

6. The Police case argued before me is two-fold:

    (a) As per their acceptance of liability, they accept that Mr Cooper suffers a psychological injury but they argue for a referral to an Approved Medical Specialist (AMS) that seeks an assessment of permanent impairment as a result of two separate injuries as follows:

        (i) injury on 18 March 2012 (as a result of the death in custody)
        (ii) injury deemed to occur on 18 June 2014 (as a result of the events that took place following the death in custody)

    (b) That there is no basis for the referral to the AMS to comprehend any events that took place prior to 18 March 2012.

PROCEDURE BEFORE THE COMMISSION

7. The parties attended a conciliation conference/arbitration hearing on 13 December 2017. The parties were both legally represented. Mr Barber of counsel appeared for Mr Cooper and Mr Tanner of counsel appeared for the Police. The matter was adjourned to a further conciliation conference/arbitration hearing on 28 February 2018. The parties were both legally represented, however this time Mr Calloway of counsel represented Mr Cooper and Mr Tanner of counsel continued to appear for the Police. 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

8. 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 with the exception of the reports of Dr Vickery and Professor Robinson which are not relied upon;

    (b) Late documents filed with an Application to Admit late Documents on 17 October 2017, and

    (c) From the late documents filed 13 February 2018, the applicant relied upon a questionare dated 7 December 2015 adressed to TMF which has been marked exhibit "A".

    For the Police

    (a) Reply and all attached documents with the exception of the report of Dr Vickery upon which the Police elects not to rely except as to history.

Oral evidence

9. Mr Cooper did not seek leave to adduce further oral evidence and the Police did not seek leave to cross-examine him.

FINDINGS AND REASONS

10. Mr Cooper served as a police officer from 1997 to 18 June 2014 when he went off work and did not return.

11. Mr Cooper's case is that he suffered a psychological injury as a result of exposure to trauma throughout his police career including the death in custody and the sequelae that followed that event.

12. He brings a claim for lump sum compensation as a result of psychological injury alleged deemed to occur on 6 May 2017.

13. The Police do not dispute that Mr Cooper suffers a psychological injury.

14. The Police accept that Mr Cooper suffered a psychological injury in the form of PTSD as a result of the death in custody on 18 March 2012.

15. Indeed, the section 74 notice 21 July 2017 accepted that Mr Cooper had suffered a psychological injury which "was caused by the events of 18 March 2012 and subsequent perceived disgrace".

16. However, the police argue that Mr Cooper should be found to have suffered a separate and distinct psychological injury, with a deemed date of 18 June 2014 as a result of the events which followed the death in custody, including the internal investigation which followed, the coronial inquest, the alternate duties Mr Cooper was placed on and his perception of how he was treated by his employer and his fellow police officers.

17. What the Police say is that Mr Cooper should be found to have suffered a separate and distinct psychological injury by reason of the events after 18 March 2012. Counsel for the Police submitted that it is a different injury with a different diagnosis to the PTSD from the event of 18 March 2012.

18. On this basis, the Police contend that the referral to the AMS should seek an assessment of the degree of permanent impairment, if any, based on two separate injuries, if any, as follows:

    (a) As a result of injury on 18 March 2012 (as a result of the death in custody), and

    (b) as a result of injury deemed to occur on 18 June 2014 (as a result of the events that took place following the death in custody).

19. The police also contend that there is no basis for the referral to comprehend any psychological injury as a result of exposure to traumatic events in the course of his police career prior to18 March 2012.

20. Mr Cooper says that exposure to trauma throughout his police career, including the death in custody event on 18 March 2012 and its sequelae, has had a cumulative effect on his psychological condition, such that one injury should be deemed to have occurred on 6 May 2017.

21. Counsel for the Police agreed that if Mr Cooper is successful in his argument, then the deemed date of injury upon which the referral should be based is 6 May 2017, when the claim was made.

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

23. Mr Cooper gave evidence in a statement dated 16 August 2017.

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

25. However, counsel for the Police submitted that the statement represents an attempt to retrospectively develop a case for PTSD deriving from events prior to 18 March 2012.

26. Mr Cooper commenced his police career in 1997. He gave evidence about various traumatic events to which he was exposed throughout his police career. These included attending on murder scenes and dealing with the bereaved families of victims of accidents, domestic violence and murders. He gives evidence as follows:

    "DECEASEDS

    56. There were a number of murders where I had to attend the scenes.

    57. I also was required to attend LIVERPOOL HOSPITAL to guard the victims. I can remember having to guard one victim and wait for DETECTIVES to arrive. He died before they arrived.

    58. I also attended numerous suicides and concerns for welfare where elderly deceased persons were located within the premises.

    59. Some had been dead for periods of time and were in various stages of decomposition.

    60. I also had to deliver death messages to families.

61. This was a very depressing duty as the families would always become emotional and we had very little training if any in relation to grief counselling.

62. In the GREEN VALLEY area were situated a number of OUTLAW MOTOR CYCLE GANGS (OMCG) including the REBELS, LONE WOLFS and BANDIDOES.

63. There were a number of drive by shootings and every so often we had to attend local HOTELS and PUBS where disputes had arisen between the gangs and fights occurred."

27. Counsel for the Police submitted that there is no evidence that exposure to trauma at work was causing Mr Cooper psychological disturbance prior to the death in custody event of 18 March 2012. Whilst I take into account that there was no contemporaneous report of any psychological symptoms being experienced by Mr Cooper as a result of exposure to trauma prior to the event of 18 March 2012, I must weigh this evidence in the balance with the other evidence that is before me including Mr Cooper's statement of evidence about which he was not cross-examined and the opinion of his treating Senior Clinical Psychologist Dr Ashleigh Craig who was treating him for psychological injury as a result of exposure to trauma throughout his police career. Moreover, it is not determinative of a claim for psychological injury as a result of the cumulative effect of exposure to trauma, that no treatment is sought along the way and prior to the onset of the psychological condition such as PTSD.

28. Mr Cooper gave evidence about the psychological symptoms that he experiences as follows:

"At present, I continue to suffer from the following symptoms, disabilities and conditions:

(a) Chronic Post-traumatic stress disorder;

(b) Major depressive disorder;

(c) High levels of anxiety;

(d) Low mood and lethargy;

(e) Hyperarousal;

(f) Chronic insomnia;

(g) Decreased appetite and low libido;

(h) No motivation to socialise/interact with others or exercise;

(i) Feelings of helplessness;

(j) Low concentration levels/attention span;

(k) Irritability with people;

(l) Substance abuse.

Before my psychological injuries, I regularly socialised with my family and friends and had no problems meeting and interacting with people. I now have great difficulty socialising and going out in public. I avoid major events, and crowded areas I have lost all but one of my friendships. This causes me great sadness, anxiety and anger.

Prior to my psychological injuries I enjoyed fishing, four-wheel driving, camping with family and friends, social functions and friend's places for BBQ or just a day out, I was also a member of the Gosford Volunteer Marine rescue. Now I generally do not engage in these hobbies because I now find it difficult to get enjoyment from anything.

Before my injuries, I was able to carry out all aspects of personal care independently. I was motivated to maintain my appearance and personal hygiene on a regular basis. I now experience a lack of motivation and interest with regards to my appearance. My wife has to prompt me to shower and even then, I only shower every 4-5 days. I generally wear the same clothes for days on end including sleeping in them and forget to shave for 6 weeks or more.

I often miss meals and generally get by on a snack a day. Due to my poor diet, I have put on about 15kg.

I now have difficulty sleeping. I often have night terrors which wake me up and I am unable to settle again. I also have flashbacks of the traumatic incidents I was exposed as an Police Officer and in many dreams an faced with confrontation with unknown police officers. I am constantly tired.

I avoid television news and newspapers. I avoid passing scenes of previous accidents. I do not drive unless I have too and always believe I am being followed by the Police. I find it hard to breath and become tight in the chest when I see a Police car which immediately triggers my mind of incidents I have faced during my career.

I am always irritable and have angry outbursts on a daily basis. My moods have affected my relationship with my wife and child. I smoke between 40 and 60 cigarettes a day.

I drink an average of 12 to 18 beers a day. At times, I will drink 24 beers and any other alcohol in the house I can find to self-medicate. My wife no longer keeps spirits in the house unless they are well hidden from me.

I used to be a positive, healthy, outgoing and confident person. I am no longer this person. Due to my psychological injuries, I have lost my self-confidence and self--esteem/self-worth. I feel hopeless and worthless. I constantly have to find reasons not to kill myself.

I now have a low concentration level/attention span. I can no longer focus on complex tasks, instructions or situations. When I was a Police officer I was able to complete a 6-page detailed statement in under 2 hours. This document has taken me 3 days to complete only sitting down for 5 minutes at a time before I get angry and walk away. I have difficulty remembering things.

I am a Type 1 insulin dependent diabetic. I can no longer manage my diabetes without the assistance of an insulin pump and continuous glucose monitoring. Every time I get angry, stressed or other emotion this has a direct effect on my blood sugars. Prior to the insulin pump I suffered many severe hypo's where I had become unconscious and fitted requiring ambulance and at times hospital intervention."

29. Counsel for the Police pointed to the report of Dr Vickery which has been admitted only as to history and not opinion. He points to the fact that Dr Vickery's report is silent as to whether exposure to any trauma prior to 18 March 2012 in the course of his police career impacted on Mr Cooper's psychological condition.

30. He says that I can infer an experienced psychiatrist would have asked of a police officer about exposure to trauma during his police career and the fact that it is not recorded in the report is because Mr Cooper didn't report any problems in this regard.

31. Dr Vickery does not record that he asked Mr Cooper about exposure to prior trauma and the effect it had on him. It is simply silent on this. I have to deal with the report as it is written, I can't speculate about what Dr Vickery may or may not have asked. I can't draw the inference suggested by counsel for the Police.

32. Professor Robertson who Mr Cooper saw at the request of the Police on, 10 August 2016 provided a report dated 12 August 2016.

33. Professor Robertson records that he specially asked Mr Cooper about prior trauma and he said that he had seen shootings before and it didn't affect him.

34. Counsel for the Police points to this specific disavowal by Mr Cooper. He didn't put anything to Mr Cooper in this regard in cross-examination.

35. I take what Mr Cooper told Professor Robertson into account but I have to weigh it in the balance with the other evidence.

36. That other evidence includes Mr Cooper's statement about which he was not cross-examined. It includes the fact that Mr Cooper was in fact being treated by Dr Ashleigh Craig, senior clinical psychologist for PTSD as a result of the cumulative exposure to trauma over his police career.

37. Moreover, it is not for a lay person to diagnose his own medical condition.

38. Mr Cooper relies upon the opinion of IME, Dr Bertucen who has provided a report dated 23 January 2017, after review of Mr Cooper, and a supplementary report dated 15 September 2017 after review of further documentation.

39. In Dr Bertucen's first report he recorded a detailed history as follows:

> "Mr Cooper is a 44-year-old man living with his wife Brooke (together eight years), and 4-year-old son in their mortgaged home in Narara, Central Coast, New South Wales. He has no other children. Mr Cooper is not currently employed and has not returned to any form of gainful employment since resigning from New South Wales Police Force on 6 December 2016. Prior to this, his last active day of work was in June 2014 as a sergeant in a clerical role in a non-police building in Parramatta, which he described as 'staring at the ceiling all day.' Mr Cooper felt compelled to withdraw as he stated that he had 'virtually nothing to do, and I found out that the role was basically just something to shut me up and keep me on the sidelines' (see below). He ascribes his failure to return to work to a number of persisting psychological symptoms including high levels of social and interpersonal anxiety, fear of being identified as the person responsible for a public death in custody in March 2012 (and vilified as a result), emotional dysregulation, impaired attention/concentration, and heavy chronic alcohol abuse. He currently receives WorkCover and TAL income protection payments. Wife, Brooke, is a police senior constable engaged as a childhood safety education officer.
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> Mr Cooper was attested as a police officer in May 1998. For several years prior he had worked at the Peter Warren Toyota dealership in western Sydney as a car salesman. He stated that he had a longstanding desire to become either a police officer or a pilot 'but as a diabetic, being a pilot was no go.'
>
> After graduating from the academy, Mr Cooper was initially posted to Fairfield in general duties. He stated that he had difficulty dealing with local (Assyrian) gangs, that a police officer had been stabbed to death in a local pub the year before while off duty. As a result, he said that there was a tight bond of camaraderie into which he was accepted, with 'a massive drinking culture.' Mr Cooper described a sharp increase in his alcohol intake after joining the police and stated that within two or three years of his

attestation, drinking was ‘a major part of my working life - it was just an accepted thing’ especially at the local Cambridge Hotel ‘which was very good to the police.’ Often ‘breakfast was beer and by 1999-2000 he was drinking perhaps 6 to 8 standard drinks at least four nights a week with regular binges on weekends or when off duty.

In 1999, Mr Cooper transferred to Cabramatta and was involved in Operation Pacini as a uniformed officer dealing mostly with street drug crime. During this period, he recalled a salient traumatic incident when ‘a ST gang member was shot in the car right in front of us... I put my fingers in the bullet hole to try and stop the bleeding and took a dying declaration from him (implicating other gang members).’

In 2000, Mr Cooper transferred to Green Valley which was an extensive and busy LAC, in general duties. During this period, he undertook an undercover course and became a ‘street level operative’ engaged in plainclothes work in Cabramatta. This was a highly dangerous and tense role in which he was frequently threatened with violence or death, or at other times expected to partake in drug use. He later participated in the SLO Field Intelligence Units. In early 2003, Mr Cooper was distressed to be mentioned in an internal investigation, on suspicion of drug use or drug dealing. Mr Cooper vigorously denied these accusations. He was never officially exonerated, however heard no more about the matter. He stated that he was also on another occasion placed under brief wrongful arrest. The accumulation of these distressing incidents disillusioned him with police work in Green Valley and led him to seek transfer.

In 2003, Mr Cooper transferred to Redfern where he continued to work successfully in stressful and dangerous undercover drug work. Over the next 12 to 18 months, he noted an increase in sleep disturbance as well as mood changes, irritability and impatience, and heightened alcohol consumption. In October 2004, he was detained in Hornsby Hospital after an acrimonious split with his girlfriend. He was intoxicated and threatened suicide and was retained under the Mental Health Act until the following morning under police guard. The issue is dealt with in a report contained within the file by Dr Murray Wright (consultant psychiatrist) (dated 15 December2004).

Following this incident, Mr Cooper took six weeks away from work during which he had several follow-up sessions with a psychiatrist at the Hornsby Community Mental Health Centre. During this time, he reports that alcohol intake was ‘out of control” however, his HOD psychological claim related to this incident was declined. In December 2004/early 2005, Mr Cooper was obliged to return to work as ‘I had run out of money”. During this period, Mr Cooper's type I diabetes condition also became under poor management and he lost his licence for three months following a collision. Mr Cooper returned to Redfern initially in a restricted role in a cell complex ‘watching exhibits ... I was given a computer and told to just play games.’ Shortly afterwards, he transferred to Computer Crime Unit in the City Central branch which was a reasonably stable and successful period of professional life. He was promoted to sergeant and served at the Auburn Computer Crime Unit briefly in 2006. The following year, he transferred back to the City Central Station and worked for several years as a sergeant. He was promoted to acting inspector in June 2012.

In March 2012, Mr Cooper was involved in a tragic and well-publicised incident in which a Brazilian student who was tasered multiple times following a shoplifting misdemeanour, and subsequently died. Following this incident, Mr Cooper did not take any significant time away from work but was given a basic debrief in which a psychologist called to speak to him and the other officers involved. Aside from this, Mr Cooper claims that there was no direction by management to attend the PMO or contact an EAP psychologist, or any official inquiries as to his psychological welfare aside from a single call from Commissioner Andrew Scipione which he felt was ‘being read from a structured statement.’

Mr Cooper decided to seek private counselling at this point and was referred to Ashley Craig, a psychologist on the Central Coast. He did not receive any other mental health treatments and continued over the next few months in his role as acting Inspector in a non-frontline position redesigning aspects of the police computer system.

Later in November 2012, however, Mr Cooper participated in the coronial inquest into the death of the offender and was required in court for two days. He found this was a gruelling and distressing process and claims that he was sharply criticised for not supervising his junior officers adequately but moreover, for shifting blame to these officers, which he vehemently denies. As a result, Mr Cooper referred to the DPP (but there were no charges laid) and claims that he became persona non-grata among his supervisors and many colleagues, who felt that he had brought the police force into public disrepute. He believes that he was vilified and ostracised by many of his police colleagues following the inquest and into 2013.

In June 2013, Mr Cooper was summoned to a meeting with superintendent Keith Willett and was informed that as a result of a Commissioner's letter 'and the public opinion against me,' his inspector's position as well as his role was to be terminated immediately. He was given a brief period of time off and then worked in a police link Triple O call centre in Tuggerah. In January 2012, he was relocated to another clerical role (which he described as 'an SAP upgrade job') with the civilian team based in Parramatta.

Over the next few months, however, he felt that he was being completely marginalised and shelved and as he put it 'stared out the window all day.' In June 2014, he made the decision to resign after being informed by a friendly colleague that 'there has been a full team doing everything that you are meant to be doing for the last 12 months-it is a made up job designed to shut you up.'"

40. Under "psychological sequelae", Dr Bertucen sets out the following;

"Mr Cooper denied suffering any pre-existing or underlying psychiatric conditions at the time of joining the police force in 1997. He also denied any significant competing psychosocial stressors at that time, which might have subsequently heightened his vulnerability for mental illness. As a general duties police office for the first few years of his career, he was subjected to a plethora of exposures to traumatic, gruesome and occasionally dangerous workplace scenarios, including suicides, recovery of deceased persons, fatal motor vehicle accidents and particularly in his undercover drug work, contact with violent criminals and frequent threats to his safety and physical integrity. Mr Cooper in retrospect believes that he began to experience symptoms of posttraumatic stress disorder as early as 2004 (aggravated by heavy alcohol abuse), although these symptoms appeared to have remitted over the next few years and his career progressed in 2006 with his promotion to sergeant. As a result of being terminated and demoted without warning in mid-2013, Mr Cooper was devastated and experienced a sudden and profound regression of many previous psychological symptoms. As a result of the sense of isolation and betrayal by many of his colleagues and by the organisation, he began to experience a recurrence of flat, depressed mood, explosive mood swings and hyperarousal, marked sleep disturbance with nightmares of previous traumas, reduced libido and socialising, and frequent quarrels with Brooke. The domestic situation was made worse by financial constraints (a drop of $40,000 per year following his demotion) and struggles with the responsibilities of first-time parenthood. Mr Cooper claims that from June 2013, his alcohol intake again escalated to hazardous levels and he stated, 'drinking was the only thing that stopped me from getting into the car and doing something stupid like driving into a tree.'

In June 2014, Mr Cooper's GP referred him to a local psychiatrist, Dr David Butler, and he accepted psychotropic medications. There have been no private mental health admissions or presentations although Dr Butler has strongly advised a three-week inpatient stay at a private hospital to address the alcohol consumption. He continues to see Dr Butler every three to four weeks and his psychologist, Mr Craig, every two to four weeks

Currently, Mr Cooper reports ongoing hazardous alcohol consumption – 'a minimum of 18 beers a night' and this has persisted over the last 12 to 18 months. As a result, his type 1 diabetes condition has deteriorated and he uses an insulin pump. Mood remains highly agitated, anhedonic and suspicious and he maintains (perhaps not implausibly) that he has been under surveillance near his home over the last 12 to 18 months. Socialising has dropped to virtually nil and he states that his daytime routine essentially consists of sitting at home watching television and drinking. He rates his mood as '3/10 to 4/10' most days. He denies any actual deliberate self-harm at any time despite frequent, fluctuating suicidal ideation."

41. Dr Bertucen conducted a mental state examination of which he records as follows:

> "Mr Cooper presented punctually for the interview and was unaccompanied having driven to Newcastle without a support person. He was a medium-built gentleman with receding hair and several days' growth of beard, slightly unkempt in appearance and casually attired in a polo shirt, shorts and trainers. He initially presented with a highly agitated demeanor and sallow complexion and needed to excuse himself within the first five minutes of the interview to go to the bathroom and 'be sick'. Thereafter, he appeared to settle and was polite and cooperative at the interview at all stages. Rapport was able to be established. Attention, concentration, and eye contact were adequate and appropriate and speech rate, volume, and content were within normal limits. He was an articulate if somewhat over-inclusive and tangential historian. Mood could be described as frankly depressed and easily agitated/irritable and this was reflected in a mood congruent restricted affect There was no formal thought disorder, evidence of psychosis, self-banning ideation or features of elevated mood/hypomania. He was oriented to time, place, and person and his sensorium was clear."

42. Dr Bertcuen made the following diagnosis:

> "In my opinion, Mr Cooper is suffering chronic posttraumatic stress disorder and comorbid major depressive disorder. In my opinion, Mr Cooper also meets sufficient diagnostic criteria for a diagnosis of secondary chronic alcohol dependence/abuse. This is a severe condition in Mr Cooper's case and combined with his diabetic condition is likely to result in serious health consequences within the next few years if not curtailed."

43. Dr Bertucen underlined the guarded nature of the prognosis:

> "Prognosis, in my opinion, is very guarded, given the persistence and intensity of symptoms despite multidisciplinary, consistent mental health treatments, and in my view, will be largely determined by his ability to abstain from alcohol over the next 6 to 12 months or otherwise."

44. Dr Bertucen answered a series of specific questions as follows:

> ***"(a) Your opinion as to whether any psychological injury from which Mr. Cooper suffers has been substantially contributed to by his duties with the New South Wales Police Force.***

On the balance of probabilities, in my opinion, Mr Cooper would not be suffering his current psychological conditions if he had not been employed by the New South Wales Police Force between 1997 and 2014 (i.e., if he had been in any other occupation throughout that period). In my view, the repeated exposure to traumatic incidents and scenarios as well as his involvement in the death in custody event of 2012 (and subsequent perceived disgrace) have been the substantial contributing factor to his current situation.

(b) *In your opinion, has Mr. Cooper's period of restricted duties towards the end of his career and prior to his resignation, caused an aggravation or exacerbation of the symptomatology associated with his phycological injury? If so, please provide reasons for your answer.*

Mr Cooper was suddenly informed in mid-2013 that he was to be demoted and that his work (which he believed was purposeful and effective) was being wound up. Thereafter, he found himself effectively 'shelved' as a persona non-grata within the organisation and his final position (in Parramatta) while initially somewhat menial, was shattered by the revelation from a colleague that he had been placed in a kind of artificial bubble for the express purpose of keeping him occupied and 'quiet.' This represented for Mr Cooper a final betrayal by the parent organisation and he found it incapable to continue exercising his function as a police officer after this point, even in his restricted role."

45. Dr Bertucen provided a further report on 23 September 2017 without further review of Mr Cooper. He reviewed various documents and reported, in answer to specific questions, as follows:

"Does any of the of the material provided alter your previously expressed opinion? If so, how?

I have had the opportunity of reviewing the material provided by the insurer as well as a copy of a report by Dr Craig as well as medico-legal reports and correspondence by a variety of clinicians including, Dr David Butler, (Mr Cooper's psychiatrist) and assessing psychiatrist, Prof Michael Robertson (12 August 2016). After considering this material, I am not persuaded to amend my opinions as expressed in my report of 23 January 2017 in that Mr Cooper's chronic posttraumatic stress disorder condition was, on the balance of probabilities, caused by cumulative exposure to a plethora of traumatic events throughout the course of his police career between 1997 and 2014. His involvement in the death in custody of Mr Roberto Curti in 2012 served, in my opinion, as the substantial and salient aggravating factor precipitating the onset of psychological symptoms; however, I consider that even if this event had not occurred, Mr Cooper would have faced a high likelihood of psychological decline and disabling illness at some stage in his career.

1. *Please advise whether, in your opinion, Mr Cooper's diagnosed psychological injury, more likely than not, has been contributed to by the events detailed in his statement? Please provide reasons for your answer.*

I had the opportunity of reviewing Mr Cooper's personal statement contained within the file which is detailed and consists of 341 separate numbered points. Mr Cooper refers to numerous specific traumatic incidents within the course of his police career which he believes had contributed (collectively) to the current psychological profile. In particular, he detailed as early in 2003 an episode in which he was assaulted by an offender, then subject to vexatious allegations of racism by the offender after which the charges were dismissed. This was despite Mr Cooper being punched in the face and suffering injuries inflicted by the offender. Mr Cooper recalls being greatly distressed by having to be interviewed by police regarding the man's allegations and was never informed of the

results of any findings against him. This was the first occasion of psychological HOD claim and led to a period of protracted heavy alcohol intake and the loss of a relationship.

Further traumatic events included contamination with bodily fluids in October 201I (and an anxious three months' wait until serology could be returned as negative). The majority of the second half of Mr Cooper's statement was given over to a description of the death in custody of Mr Curti, the subsequent investigations that he was subject to, his psychological treatment and symptomatology following this incident.

In summary therefore, I consider that on the balance of probabilities, Mr Cooper's diagnosed and accepted psychological injury has been substantially contributed to by the aggregation of events detailed in his statement.

2. *The worker's compensation insurer for the New South Wales Police Force allege that Mr Cooper's injury, causative of his permanent impairment, was caused by events of 18 March 2012 and his subsequent perceived disgrace only. Do you agree with this proposition? Please provide reasons for your answer.*

I cannot agree with this statement; as viewed longitudinally, Mr Cooper was, in my opinion, exhibiting fluctuating levels of mental illness since at least 2003 as evidenced by periods of heavy alcohol abuse, periods of depressed mood and a period of withdrawal from work in 2003 following the events described above.

Consequently, I do not agree that his permanent impairment has been solely (or even substantially) caused by the events of March 2012 and the subsequent perceived disgrace. This has been naturally a very significant aggravation and the events themselves were, in my opinion, overshadowed by the subsequent response of the employer i.e., a perception that he had been stripped of rank and responsibility and "exiled" to an open-ended menial position with the deliberate intent for him to later resign.

3. *We note that in 2003 Mr Cooper was unlawfully arrested in 2004 he was admitted to Hornsby Hospital In the context of these events you note that Mr Cooper was undertaking stressful undercover work and noted changes in his mood, irritability and mood changes.*

   In your opinion, had Mr Cooper been assessed by an appropriately qualified psychiatrist with experience assessing police officers and PTSD would Mr Cooper, more likely than not, have been identified as suffering PTSD at that time either clinical or sub-clinical level?

Given the events of 2003/2004 (episodes of impulsive, reckless and uninhibited behaviour leading to an arrest) and the causative factors, I feel strongly that if Mr Cooper had been reviewed by a qualified professional at that time (e.g. an expert psychiatrist and/or psychologist), that a diagnosis of posttraumatic stress disorder would have been made. In retrospect, decisions could have been taken which may have altered the course/progression of the condition (e.g. initiating consistent psychiatric treatments and/or redeploying Mr Cooper to a period of non-operational police work)."

46. Counsel for the Police says that the report of Dr Bertucen simply represents an attempt to retrospectively create a case for psychological injury as a result of events prior to the death in custody event of March 2012.

47. He points out that Dr Bertucen, as an IME, has seen Mr Cooper only once and that more weight should be placed on the opinion of the treating doctor, Dr Butler.

48. Counsel for the Police point to the treating reports of Dr Butler to support his argument that Mr Cooper satisfied a separate and distinct psychological injury as a result of events subsequent to the death in custody event of 18 March 2012. The difficulty with this submission is that Dr Butler does not distinguish between the effect of the events of March 2012 and the effect of the events that took place after 18 March 2012 on the psychological condition of Mr Cooper.

49. Counsel for the Police further submitted that the reports of Dr Butler support the submission that there has been no contribution for exposure to prior trauma to the psychological injury suffered by Mr Cooper.

50. Mr Cooper was referred to Dr Butler, psychiatrist, by his treating general practitioner Dr Jayashree. Dr Butler provided a report dated 2 September 2014 to the insurer as follows:

> "Mr Cooper was referred by his GP, Dr Jayashree and I saw him for a psychiatric assessment on 28th August. In my opinion, he is suffering from a Chronic Adjustment Disorder with Anxiety and Anger which came on as a reaction with having to deal with a death in custody in March 2012 on the streets of the city in Sydney when he was working as a police inspector who was the supervising officer. The man who died was tasered many times and the police had found it very difficult to control his behaviour.
>
> Mr Cooper said he was the one that the coroner mainly blamed at the Coroners Court because he was the one who was in charge at the time even though he was finding it hard to catch up with the other police officers and did not see everything that happened. He was however involved in holding the man down on the ground at one stage. Mr Cooper feels that he was vilified in the media and in the courts and by his fellow police officers and he said that he had lost all his police officer friends since this incident. Since the death in custody incident Mr Cooper has mainly been doing police work in an office rather than his usual operational work and he found the last few months at Parramatta until June this year very difficult because he was stuck in a room with no work to do most of the time and did not have any interaction with other police officers. He eventually went off work on 18th June and has not been back to work since then. He has been off work on Workcover certificates provided by Dr Jayashree.
>
> For most of the time since the death in custody in March 2012 Mr Cooper has had a lot of problems with fluctuating moods of anxiety and anger. Early on after the incident he was having some nightmares and flashbacks but these have now gone away. He may have fulfilled the criteria for Acute Post Traumatic Stress Disorder, but I cannot say for sure because I did not see him at the time. He denies that he has been feeling depressed or suicidal. At times, he was drinking too much alcohol but in recent months he has not been drinking any alcohol at all. He often finds it difficult to sleep and feels tired when he wakes up and then feels tired for the rest of the day. He often has difficulty concentrating and says it is hard to get motivated to do things.
>
> During the session with me Mr Cooper appeared normal in his mood and there was no evidence of any suicidal ideas nor any psychotic features or cognitive impairment. He was able to talk quite well about his problems and was keen to sort things out. He had not been started on any psychiatric medication by his GP but he had been seeing a psychologist regularly and was going to continue with this.
>
> In summary then Mr. Cooper is suffering from a Chronic Adjustment Disorder with Anxiety and anger due to an incident at work in his job as a police officer which occurred in March 20l2. He needs to continue seeing his psychologist regularly and needs to see me for ongoing sessions of psychiatric treatment every two to four weeks.

These sessions would be charged at the current WorkCover rate. At this stage I have not started him on any psychiatric medication but we will talk about the need for this over the next few appointments. He was not keen to start on any medication because he was worried about side effects. He certainly is not well enough to return to work yet. Would you write back to me soon saying whether you will accept liability to pay for Mr. Cooper's psychiatric treatment as outlined here."

51. Dr Butler also provided a report dated 2 September 2014 back to the GP as follows:

> "Thank you for referring Greg whom I saw on 28th August. He is suffering from a Chronic Adjustment Disorder with Anxiety and Anger which has come on as a reaction to the death in custody that he had to deal with in March 2012 when he was working as a supervisor. He found it very difficult being vilified in the media and in the Coroners Court and he has lost most of his friends over this case. He has to give evidence in the cases of four fellow police officers who have had charges made against them. He has fluctuating moods of anxiety and anger and is preoccupied with thinking about what happened. He has been off work now from 18th June and at this stage-he still is not well enough to return to work.
>
> During the session with me he appeared normal in his mood and there was no evidence of any suicidal ideas. Fortunately, he has not been drinking any alcohol recently. I have not started him on any psychiatric medication yet but we will talk about this over the next few sessions."

52. Dr Butler's report to general practitioner dated 16 October 2014:

> "I have continued to see Greg every couple of weeks with his most recent appointment being on the 13th October.
>
> Although anger seems to be his main emotion, he does get quite depressed at times, so I started him on Valdoxan 25mg per day from the I3th October. When I saw him on the 13th October, he said he had been getting a bit drowsy at times with the Valdoxan, but he felt there was already some improvement in his mood.
>
> He has been subpoenaed to give evidence in the court case, but he is not sure whether it is still going to be on at this stage."

53. Dr Butler reported to general practitioner by letter dated 16 December 2014:

> "I have continued to see Greg with his most recent appointment being on 15th December. He stopped the Valdoxan because he felt too drowsy during the day and when l saw him on 1st December I started him on Lexapro initially at a dose of 5mg mane for five days then increasing to 10 mg. He was quite upset about having to give evidence in the court case and he felt he was very unfairly treated by the police force regarding this. He gets fluctuating moods of anger, anxiety and depression and sometimes has nightmares and difficulty sleeping. I will be reviewing him on Monday, 12th January. He said he would be away on holidays for a couple of weeks before that."

54. Dr Butler continued to treat Mr Cooper although there was a significant break in the treating relationship at one point in 2015 where Mr Cooper doesn't attend on Dr Butler for treatment for approximately three and half months. Dr Butler says Mr Cooper did not explain why he stopped attending for treatment with him, but noted that Mr Cooper continued to see his psychologist Dr Craig and general practitioner for treatment in this period.

55. Dr Butler provided a report dated 17 March 2016 to the insurer that Mr Cooper was still unfit for work and that he continued to need treatment, reporting to the insurer as follows:

> "On the 16th March, I saw Mr. Cooper for the last of the six sessions approved in October last year. He has also been seeing his psychologist Ashleigh Craig regularly. He has attended his appointments with me regularly and has also taken his medication as prescribed. The Lexa pro was increased from 10mg to 20mg per day but when I saw Greg on 16th March he said that he was feeling too tired and drowsy on this medication and asked if he could change it to another medication. He still had fluctuating moods of anger and anxiety and although he had cut down on his alcohol intake, he was still drinking excessively on some days. As discussed in the case conference on 16th March Mr. Cooper is still unfit to work and we do not know when he will be well enough to start working back with the police force. A lot of this depends on when the police internal investigation is finished and of course we have no idea when this will be. In the meantime, he will continue to need psychiatric and psychological help regularly. I would like to continue to see him for ongoing sessions of psychiatric treatment every two to four weeks, depending on the severity of his symptoms at the time. These sessions would be charged at the current WorkCover rate. Would you please write back to me saying whether you will accept liability to pay for his psychiatric treatment as outlined here."

56. Counsel for the Police submitted that the report of Dr Butler supports that there was no contribution to Mr Cooper's psychological condition from any events prior to the death in custody event because there is no mention of the effect of any prior trauma.

57. When weighing all of the evidence in the balance I take this into account. However, counsel for the Police has made much of the weight that can be attributed to a treating doctor's report as opposed to that of an IME.

58. In this regard, I note that Mr Cooper was also being treated over a significant period by Dr Ashleigh Craig, Senior Clinical Psychologist.

59. There is a series of reports by Dr Craig in evidence. These show that Mr Cooper was being treated by Dr Craig from 2012 and then from 2015 when he continued to experience psychological symptoms. I note that Mr Cooper maintained his treatment regime with Dr Craig even when he had a break in his relationship with Dr Butler.

60. Dr Jayashree referred Mr Cooper to Dr Craig a few days after the death in custody event of 18 March 2012 and he was diagnosed with PTSD and a treatment plan approved by the insurer. Dr Jayashree referred Mr Cooper back to Dr Craig in 2015 who diagnosed PTSD as a result of exposure to traumatic events in the course of his police career and Dr Craig submitted a treatment plan to the insurer which was approved.

61. Dr Ashleigh Craig provided a report dated 6 December 2016 to the insurer, noting the purpose of the report was to comment on the RTW status of Mr Cooper as a result of injury of PTSD as a result of Mr Cooper's exposure to trauma during his police career over a period of 10 years post 2000. In this report Dr Craig answers a series of questions posed by the insurer.

62. Dr Craig first noted the background to his report as follows:

> "Mr Cooper is a 43-year-old police officer who has suffered numerous traumatic incidents during his operational policing. These incidents have occurred over a long period of time from late 1990s to 2012 when he was involved in the trauma associated with a stressful tazer incident after which he was demoted and now has no active duty in the police force. He is married and has a young child. Currently, Mr Cooper is not working and has been assessed as unfit for duty by his GP over the past year. He has continued to experience stress from the internal investigation related to the tazer affair."

63. Dr Craig answered the insurer's questions as follows:

> "Do you think that Mr Cooper will have the capacity to return to work with the NSW Police in the foreseeable future?
>
> I do not believe Mr Cooper has the capacity to return to work with NSW Police. This is due to: (i) a history of serious distressing incident he has experienced in his operational duties as an officer that have elevated his distress levels. He now has probable PTSD, and this will to severely limit his operational and even his non-operational capacity. (ii) the continuing stress of internal investigations has had a serious debilitating effect ion his physical and mental health.
>
> In your opinion, is a RTW with NSW Police (in either an operational or non-operational capacity) a realistic RTW goal? please explain.
>
> For the above reasons strongly suggest that a RTW with NSW Police would definitely have a negative impact influence on his functional capacity to work and remain healthy. Non-operational duties can also be distressing, invoking PTSD symptoms merely because he would be working in a police environment, refreshing distressing memories. Also, it does not resolve the investigative adversarial internal affairs that he has continued to experience.
>
> What impact would RTW with NSW Police likely have on Mr Cooper's health?
>
> Most certainly, his physical health would continue to decline contingent on continued exposure to stimuli that provoke his PTSD, as well as the effect of the toxic effects of the internal investigations that he has experienced and would likely continue to occur if he returns to NSW Police. His mental health would also continue to deteriorate so that his PTSD would also develop into a co-morbid depression, work capacity in such a state would be severely limited.

64. Dr Craig recommended that Mr Cooper be discharged from NSW Police and that he continue to receive treatment for his psychological injury.

65. The submission by Counsel for the Police that there is no basis for the claim for psychological injury as a result of exposure to trauma throughout Mr Cooper's police career, is not supported by the diagnosis of Dr Craig, an experienced clinical psychologist with whom Mr Cooper had an extensive treating relationship.

66. Professor Robertson, psychiatrist, was qualified by the Police to provide and independent medical opinion. He saw Mr Cooper on 10 August 2016 and provided a report to the Police on 12 August 2016.

67. Professor Robertson took a history as follows:

> "Mr Cooper is a 44-year-old man. He Is married and has a three-year-old son. He was attested in 1998. He last worked on 20 June 2014.
>
> Mr Cooper reported that his most recent duties were various roles including a period at the 000 Call Centre and off-site in Parramatta. He had taken on these duties much to his chagrin, as he regarded his substantive position was with Business and Technology Services (BTS) at the Parramatta Police Centre, effecting the developing or improvement of computer systems to enable day-to-day police activity.
>
> Mr Cooper reported that throughout his police career he had encountered numerous traumatic events, none of which he believed had adversely affected his mental state.

Mr Cooper attributes his difficulties over the last few years as stemming from the well-publicised death in custody of a male offender ('Curti') on 22 March 2012. The details of Mr Curti's death are well-documented and a matter of public record. Mr Cooper emphasised that as the senior officer on the scene he was ultimately responsible for the actions of his charges, however he believes that he was "crucified" by the media as well as being subject to adverse comments from the coroner and what he regarded were inordinately protracted investigative processes from the Police Integrity Commission and subsequently Professional Standards Branch.

Mr Cooper had sought treatment from his nominated treating doctor in the period following the incident and its aftermath and he was diagnosed with acute post-traumatic stress disorder and placed off work.

He was referred to psychological therapy.

Mr Cooper was offered suitable duties but was provided with a certificate in mid-April 2012 certifying him fit for pre-injury duties.

The circumstances of Mr Cooper ceasing duties in mld-2014 were his being summonsed to Court. He submitted to Independent Medical Examination by Dr Vickery who did not diagnose post-traumatic stress disorder but rather highlighted his grievance with the employer producing a depressive illness and Indicating that he would be likely to return to office duties in an administrative role and perhaps returning to full-time pre-injury duties in a six-month timeframe.

In September 2014, Dr Butler, his treating psychiatrist, provided evidence that Mr Cooper was suffering from a chronic adjustment disorder with anxiety and depression. He submitted a further P902 form after his attendance at Court in late November 2014. I note by 2015 consideration had been given to alternative duties including Marine Command, Subpoena Unit, Operational Programs and Covert Unit or other administrative type roles.

Mr Cooper continues to be certified unfit and remains at odds with his employer. He is particularly aggrieved that he was compelled to give evidence "as a civilian"- referring to his medical certification. He reported that the Police Association had become involved in the matter. There Is ongoing investigation through the Professional Standards Branch.

Beyond the convoluted and complex nature of his disputes with his employer, Mr Cooper reports that his symptoms of post-traumatic stress disorder have attenuated. Nightmares and flashbacks are usually precipitated by stimuli salient to the incident."

68. Professor Robertson noted the current symptomology as follows:

"Mr Cooper noted the recent Rio Olympics were not as apt to produce symptom recrudescence: as the recent Soccer World Cup in 2014 with its incessant reference to the host nation "Brazil" I assume this refers to the salience of Mr Curti's country of origin.

Mr Cooper reports that his sleep is poor and unrefreshing. He has initial and middle insomnia and finds it hard to settle at night. He is hypervigilant and describes being "a helicopter parent". He is able to take his three-year-old son to Gymbaroo or other play group assignations, but tends to find the process overwhelming and does not seek to socialise with other parents.

Mr Cooper is irritable. He complains of an exaggerated startle reflex. His mood is chronically dysphoric and he has a reduced capacity for enjoyment. He frequently ruminates over his treatment at the hands of the employer. He describes a modicum of cognitive impairment. He is inattentive, forgetful and has difficulty persisting at tasks.

He remains in treatment with Dr Butler, whom he sees periodically and has been prescribed the anti-depressant medication desvenlafaxine, 50 mg daily. He has been in long-term psychological therapy with Ashley Craig, a Psychologist.

Mr Cooper reports that he Is routinely binging on alcohol and this pattern of drinking has escalated particularly in light of the lead up to this assessment. He has also begun to smoke cigarettes, In excess of forty per day. He does not believe that his alcohol use has left his control stating he could take it or leave it, often being able to abide self-imposed periods of sobriety. He denies any features of alcohol dependency.

Mr Cooper reports that the difficulties and travails of the last two to four years have seriously destabilised his diabetic state. He reports that he is routinely demonstrating blood glucose levels above 10, likely the effect of stress hormones as well as, I assume, unhelpful lifestyle choices."

69. Professor Robertson recorded past psychiatric history as reported by Mr Cooper as follows:

> "Mr Cooper denied any previous manifestations of psychiatric disorder. He particularly remembered witnessing the shooting death of an offender in 2002 without serious psychiatric sequelae.

70. Professor Robertson noted under "forensic history" as follows:

> "I note the complexity of the legal and medicolegal consequences of recent events. He denied any previous disciplinary matters although given the tenuous rapport, I did not explore this in any depth."

71. Counsel for the Police has highlighted that Mr Cooper did not disclose to Professor Robertson that any prior trauma affected him and in fact, he specifically disavowed it. I take this into account but this must be balanced in the context with the other evidence that is before me, including the fact that Mr Cooper was being treated by Dr Craig for PTSD as a result of the effects of cumulative exposure to trauma throughout his police career. Professor Robertson himself notes that tenuous rapport he was able to establish with Mr Cooper in his IME assessment and on this basis for example prior disciplinary matters were not explored in any depth. Moreover, it is not for a lay person to diagnose his own condition or to be able to diagnose the effect that cumulative exposure to trauma has had on his mental health.

72. Associate Professor Robertson conducted a mental state examination and reported in this regard as follows:

> "Mr Cooper attended the interview alone.
>
> He was agitated and clearly at the interview under sufferance, but given the circumstances he engaged reasonably and was appropriate in his interactions.
>
> He answered questions in a fluent and a times over-inclusive fashion. His affect was labile and his mood was dysphoric. He showed no obvious signs of being drug or alcohol affected. He did not appear to be physically unwell. There were no signs of psychosis or dissociation. There was no disorder of thought form or content or psychomotor changes evident. He denied being suicidal and there was no evidence of recent injury."

73. Professor Robertson made the following assessment:

> “Mr Cooper Is a 44-year-old currently serving police officer who presents with a chronic adjustment disorder with anxiety and depressed mood. It is likely he had a period of acute post-traumatic stress disorder. These symptoms have attenuated or subsided and would under the DSM-S classification system be considered “cross cutting features” of the condition. He is also abusing alcohol.
>
> Mr Cooper was clearly traumatised by the circumstances of the death of Mr Curti and certainly feels significantly aggrieved both by the criticism he was subject to in both the lay media and through the coronial inquest process. He also is angered that he was placed in employment away from his substantive position throughout 2013 and being removed from his acting inspector role. He was reluctant to persist with the Triple Zero call centre role in 2013 and found the special project in Parramatta a demeaning experience.
>
> The issue appears to be Mr Cooper's fitness for duty and there appears to be something of an impasse on this question.
>
> Mr Cooper indicates that his current psychiatric distress is highly circumstantial, insofar as the persistence of enquiries and procedures around the 2012 incident aggravate his mental state by serving as a constant salient source of distress.
>
> To paraphrase Mr Cooper at the interview, "*If they wind up this situation promptly, I can get back on with my career*".
>
> This statement is only partially justified.
>
> I certainly accept Mr Cooper's account of his current distress being more in reaction to an ongoing problematic relationship with the employer but beyond this there ls the question of the actual traumatic stressor underlying the presentation. Mr Cooper was involved in a horrendous incident in which an offender died as the consequences of actions of police. Mr Cooper had command responsibility during the incident and was, in his view, appalled at the behaviour of one particular officer whose seemingly sadistic and recklessly indifferent behaviour led to a man's death. This is in itself a traumatic event that explains a component of Mr Cooper's ongoing mental health difficulties. Any reasonable person would likely have experienced a similar response.
>
> Mr Cooper's post-traumatic psychological adjustment has been significantly affected by various processes relating to Mr Curti’s death. The Police Force's investigations and internal processes appear to be the more significant issue for Mr Cooper. Beyond this, he likely sustained a period of acute PTSD following the incident and presents as an ”at risk mental state”.
>
> Mr Cooper indicates that he has little or no transferable skills to find employment outside the workforce and the prospect of being job detached from the Police Force is, to him, anathema.
>
> In attempting to reconcile these two perspectives, it seems a reasonable ”middle ground” would be for Mr Cooper to be provided with a certificate of permanent modification of duties and the specifics of this are that he not work in circumstances where he would be placed with the potential exposure to graphic or traumatic material - such as operational policing, Exhibits, Forensic Services Group or handling intelligence or intercepts that may expose him further to traumatic material.

Mr Cooper is capable of engaging in a process of rehabilitation to these modified duties and there are no psychiatric grounds to preclude this happening presently.

Moreover, his insistence of a prompt resolution to the investigative processes around the 2012 matter indicates that he Is psychiatrically fit to participate in good faith in such processes as needed to help resolve the situation."

74. Counsel for the Police highlighted that Mr Cooper said that he could go back to work if the internal investigation was wound up promptly. Counsel for the Police said this supported the case for a separate injury being deemed to occur June 2014 because this is what Mr Cooper was reporting as the crux of his problems. But it is not a lay person to diagnose his own condition. Professor Robertson, as an experienced psychiatrist, recognises this when he points out that it is the underlying post-traumatic stress that is the true barrier to Mr Cooper's RTW and indeed that his traumatic stress exposure indicates that his restriction for duties is permanent and that any return of Mr Cooper to policing work would be negligence on the part of the Police. This is evident in the opinion that Professor Robertson expressed in his answers to the specific questions he was posed as follows:
"

1. ***Considering the rehabilitation and duration of absence that the employee* has already undertaken, do you consider that the employee's situation regarding fitness for work with *NSW Police Force has become* permanent/likely to persist for the foreseeable future?**

Mr Cooper insists that his recent absence from employment is more apropos of the impasse that he has with the employer and that resolution of this would be a significant factor in helping him return to employment. This clearly indicates a highly fluid situation and therefore the current fitness for duty is arguably temporary. His traumatic stress exposure indicates that the restriction from the duties I outlined above is, however, permanent.

2. ***What do you consider are the barriers to the employee returning to work (clinical, work, or social) and your recommendation regarding strategies for overcoming these?***

It is evident throughout Mr Cooper's narrative that he Is angered and aggrieved at the conduct of the employer and seeks to resolve this in order to return to work. It would appear that this is a necessary and sufficient condition for him to return to permanently modified duties.

3. ***Is the employee fit to engage in a rehabilitation program? (If yes, please give your recommendations regarding the appropriate type(s) and duration of rehabilitation).***

Mr Cooper indicated he is anxious to return to employment and as such it is reasonable to certify him able to participate in rehabilitation programs seeking to identify capabilities and deficits requiring intervention. This should be to permanently modified duties.

4. ***If the employee does return to work in his current position is there likely to be an increased risk of aggravation or recurrence? In other words, if the employee were to return to his current work, will NSW Police Force be able to continue to meet its duty of care to provide a safe working environment to him?***

I agree that Mr Cooper is an at risk employee as he is exhibiting chronic psychiatric symptoms arising from traumatic stress exposure.

> Following this logic, placing him in employment circumstances where he would be further traumatised and likely to experience further deleterious effects on his mental state. This would represent a negligent act on the part of the employer.
>
> Mr Cooper Is likely to be aggrieved with this advice, however beyond the particular aspects of his grievance with the employer it is clearly evident that any further traumatic stress exposure will have adverse consequences for his mental health."

75. What Professor Robertson says about the risk of Mr Cooper returning to work and being exposed to further trauma, is consistent with the opinions of both Dr Bertucen and the treating Senior Clinical Psychologist Dr Craig. Professor Robertson, Dr Bertucen and Dr Craig all diagnose Mr Cooper as suffering from PTSD. The treating psychiatrist Dr Butler held a different view as he did not consider that Mr Cooper suffered from PTSD but that he had a chronic adjustment disorder with Anger and Anxiety.

76. When all of the evidence is weighed in the balance, for the reasons given throughout, I prefer the opinion of Dr Bertucen as supported by the opinion of the treating psychologist Dr Craig. On this basis, I am satisfied on the balance of probabilities that Mr Cooper has suffered a psychological injury in the course of or arising out of his employment as a police officer as a result of exposure to trauma throughout his police career since 1997, including the event on 18 March 2012 and the events which followed it, with a deemed date of injury of 6 May 2017. It should be sufficient in my view to find psychological injury as the WorkCover Guides provide that the AMS to whom the matter will be referred will make a psychiatric diagnosis. However, if it is necessary for me to apply a "label" to the injury so found, then I prefer the opinion of Dr Bertucen, as supported by the treating psychologist Dr Craig, that Mr Cooper suffers "chronic posttraumatic stress disorder and comorbid major depressive disorder."

77. On this basis, the matter will be remitted to the Registrar for referral to an AMS to assess the degree of permanent impairment, if any as a result of psychological injury deemed to occur on 6 May 2017. The documents to be forwarded to the AMS are those documents admitted into evidence in these proceedings.