CASE STUDIES:

PSYCHIATRIC ASSESSMENT OF ROAD TRAFFIC ACCIDENT CLAIMANTS

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CASE STUDY 1

Name:	Mr Brian SMITH
Age:	38 years
Date of Accident:	11 July 2003

HISTORY

Mr Brian Smith is a 38 year old former truck driver who was involved in a road traffic accident on 11 July 2003. He has received a disability support pension since early 2005 and last worked approximately five months after the accident, at which time he took an overdose of medication and drank two bottles of Wild Turkey. He had been employed in his previous position with a transport company for seven years at the time of the accident, and in all, worked as a truck driver for 12 years. Prior to this, he had worked as a builder's labourer and metal polisher. He denied any earlier road traffic accidents or history of previous psychiatric treatment. There was no family history of any psychiatric condition.

CURRENT CIRCUMSTANCES

Mr Smith resides with his wife of 20 years who is employed as a part-time cleaner and three of their four children aged 14, 11 and 9. His 19 year old daughter left home around December 2005 after increasing conflict with Mr Smith. He resides in rental accommodation. A WorkCover Claim related to the subject accident was settled for $25,000 in November 2004 after which he was awarded a disability support pension.

HISTORY OF THE ACCIDENT

Mr Smith was the driver and sole occupant of a cab over truck around 9.00pm on the Pacific Highway. Without warning, he felt his truck veer to the other side of the road. His initial thought was that he had blown a steer tyre. He then saw the flash of a vehicle which had attempted to pass him in the emergency lane. It clipped his left front wheel as it tried to merge onto the road and was caught under the truck. He attempted to brake but as he did so, the car was released from the front of his vehicle and spun into the path of an oncoming car. Mr Smith was not physically injured.

He pulled over his truck and returned on foot to the accident scene. There, he found a 36 year old woman who was dead as a result of multiple injuries and a dead 12 year old girl. He assisted in getting two other children aged 10 and 8 out of the vehicle and was near the two dead victims. The driver of the oncoming vehicle was a woman in her 30s who was severely brain damaged. Police attended promptly and other motorists stopped. It was assumed that he was at fault as the truck driver. No one spoke to him at the scene other than Police. His employer sent a truck to collect him around 1.00am. He remained at the accident scene for about four hours following the accident.

PSYCHOLOGICAL SEQUELAE TO THE ACCIDENT

As soon as he completed the two hour journey home, he began to drink alcohol. He was unable to sleep for two to three days. A psychologist visited him in his home every two to three days for two weeks at the request of his employer. When he was able to sleep, he began to experience dreams of the children in the accident who at this time were the same age as his own children. The themes of these nightmares were of the dead woman and his attempts to assist the children out of the car. His general practitioner prescribed Normison tablets.

He stated that during his two weeks off, he was frequently irritable, tearful and miserable. He resumed work at the Transport Depot but did not drive trucks. A referral was made by his general practitioner to a psychologist in September 2003. The referral letter noted that he continued to suffer sleep difficulties, lethargy, apathy, concentration problems, irritability, nightmares and that his libido was decreased. He was noted to be agitated and at times tearful. He attended regular sessions and was desensitised in imagination and encouraged to drive a truck locally. Around five months after the accident, he was asked to drive a longer haul. However, at Tweed Heads he broke down, pulled the truck over, took six sleeping pills and drank two bottles of Wild Turkey and called his boss. Thereafter, he was commenced on the antidepressant Lexapro and came under the care of a consultant psychiatrist. He was subsequently changed to 200mg of Zoloft which he continues. In all, he attended 30 sessions with a psychologist and 10 sessions with a psychiatrist.

CURRENT PSYCHOLOGICAL SYMPTOMS

Mr Smith continues to feel lost and depressed. He describes both initial insomnia and middle insomnia. He generally only gets three to four hours of sleep per night. There is marked diurnal mood variation and he describes feeling sad and empty inside. He is self-critical.

He experiences nightmares most nights of his own children in a road traffic accident. He has gained 5kg to 6kg in weight. His appetite fluctuates. His libido is diminished. He cannot concentrate to read. He states that he feels uncomfortable around others and has little social contact. He made an attempt to play Masters Football but fractured his leg in 2004, but stated prior to this he felt detached from other members of the team. He continues to drink approximately half a bottle of whiskey per night. He and his wife separated for several months last year and the relationship has been significantly strained. He drives a car around the local area but has not been able to drive a truck again since his overdose of tablets and alcohol.

CURRENT PSYCHOLOGICAL TREATMENT

He continues 200mg of Zoloft and now consults a psychiatrist on a monthly basis and a psychologist on a fortnightly basis.

CURRENT DAILY ROUTINE

He states that he seldom leaves the house and does little except play on the computer and watch television. He walks his children to and from school to ensure that they get there safely. He seldom assists his wife around the house and has to be pushed to shower some days. Arguments occur during the day. He states that he pushes himself to go out and they go out on average once a month to the local hotel. A friend may visit him at home once a fortnight. Previously, he would spend weekends at the hotel and at the TAB with his mates.

MENTAL STATE EXAMINATION

Mr Smith presented as poorly groomed and unshaven. He stated that some days he didn't bother showering. His mood was flattened. He was tearful and irritable and distressed speaking about the accident. There were obvious concentration difficulties. He spoke with a slight stutter but at normal rate. He denied any current suicidal ideation. He did not smell of alcohol at interview.

DIAGNOSIS ?

PSYCHIATRIC IMPAIRMENT RATING

Mr Brian SMITH

Psychiatric Diagnosis	
Psychiatric treatment	

Category	Class	Reason for decision
Self Care and Personal Hygiene		
Social and Recreational Activities		
Travel		
Social Functioning		
Concentration, Persistence and Pace		
Adaptation		

Classes in Ascending Order:

Median Class

=

Aggregate Score Impairment:

Total

WPI%

=

Whole Person Impairment:

%

CASE STUDY – Mr Brian SMITH

NOTES OF GENERAL PRACTITIONER

27.5.03	**Mr Smith presents in distressed manner. Made a superficial cut to his wrist after drinking a bottle of whiskey following an argument with his wife. Describes increased marital tension for 12 months.** **Alcohol abuse > 6 standard drinks most nights. Has been missing days at work. Sometimes can't be bothered to get out of bed. Wgt loss of 5kg.** **Family history of brother suiciding two years ago.** **Lovan 20mg** **Refer to psychologist**
14.6.06	**↑ Lovan to 40mg – little improvement in depressive SX.**

NOTES OF PSYCHOLOGIST

1.6.03	**BDI suggests severe depression - score 47** **Intermittent suicidal thoughts, difficulty concentrating at work, filling in log book. Lost interest in socialising apart from going to pub. Angry outbursts towards wife – close to separating – encourage to reduce alcohol – info about depression.** **Contract re self-harm.**
8.6.03	**Conjoint session with wife.** **She reports significant depressive SX over last 12/12 with irritability, loss of interest and loss of libido together with substance abuse. Has changed to light beer.**

PRE-EXISTING IMPAIRMENT

Mr Brian SMITH

Psychiatric Diagnosis	
Psychiatric treatment	

Category	Class	Reason for decision
Self Care and Personal Hygiene		
Social and Recreational Activities		
Travel		
Social Functioning		
Concentration, Persistence and Pace		
Adaptation		

Classes in Ascending Order:

Median Class

=

Aggregate Score Impairment:

Total

WPI%

=

Pre-Existing Whole Person Impairment:

%

Subtract Pre-Accident Impairment from Current Impairment:

(current) – **(pre-accident)**

IMPAIRMENT DUE TO SUBJECT MOTOR VEHICLE ACCIDENT:

= %

CASE STUDY 2

Name:	Ms Vera Nikolovic
Date of Birth:	5 January 1962
Date of Accident:	10 December 2002

BACKGROUND

Ms Nikolovic is a 41 year old housewife who immigrated to Australia from Serbia as a refugee on humanitarian grounds in April 2002. She lives with her husband of 10 years, now 43, and their 5 year old son in rental accommodation in Liverpool. She last worked as a cook in Kosovo in 1999. Her husband suffered a myocardial infarction in February 2003 and receives a sickness benefit. She has held no employment in Australia. With the civil war, because of her Serbian origins and Croatian place of abode, she lost her home and possessions.

She explained that she was returning from shopping with her son, Zoran, and was crossing a pedestrian crossing in rainy conditions. She had shopping in her left hand and her son in her right hand. A vehicle moved forward 1 ½ metres and her son rolled on the bonnet. The vehicle ran over her right foot. She worried about her son being injured and the situation was worsened by her lack of English. Her local general practitioner refused to visit. She attended the next day and he suggested she rub Voltaren cream into her foot. Some months later, a STARTTS (torture and trauma service) counsellor organised for her foot to be x-rayed. It showed now abnormality.

PSYCHIATRIC SEQUELAE

Ms Nikolovic stated that her major concern was for her son's wellbeing. Four nights after the accident it is alleged he began to cry, became fearful and started sleepwalking. Seven days after the accident, she stated that she began to develop interrupted sleep and worry. She alleged that she experienced "ugly dreams" of collisions with a train or a car which initially occurred 2 – 3 times a week but which are now infrequent.

She states that it is necessary for her to cross at the same pedestrian crossing as the accident occurred. She is able to do this but cautious. She has never held a driver's licence. She stated that she has lost a little weight but her appetite is preserved. She worries very much about the future as her husband, a fitter and turner, has suffered a heart attack.

CURRENT ROUTINE

Ms Nikolovic states that she wakes around 7am, gets her son ready for school and then walks him to school. Her days are spent doing shopping, cooking and home duties. She is attempting to learn English and does not describe difficulties with concentration. She states that generally she goes to bed around 10pm. Her sleep is satisfactory. She has some contact with Serbian speaking neighbours but describes less social interaction since the accident. She denies any conflict in the relationship with her husband. She borrows Serbian and Bosnian videos from the library but otherwise has few hobbies. She states that she experiences mild memory problems concentrating on these.

TREATMENT

Ms Nikolovic spoke to her STARTTS counsellor and continues to attend on a fortnightly basis with focus largely on acculturation problems. She was referred by this counsellor for three sessions with a Serbian-speaking psychiatrist who prescribed 40mg of Aropax. She stated that this medication was prescribed because of her worries about the family's financial position, her husband's heart attack and her son's behavioural difficulties.

MENTAL STATE EXAMINATION

Ms Nikolovic presented as neatly groomed and emotionally appropriate. She was not tearful. She spoke little to no English and was interviewed with an interpreter. She spoke at normal rate and expressed concerns about her son. There were no obvious difficulties in concentration or attention. She was tearful talking about the accident and the effect on her son.

PAST PSYCHIATRIC HISTORY

She denied any past history of torture and did not describe any previous psychological symptoms, stating that many of her friends also lost their homes and they were fortunate to come to Australia. In particular, she denied nightmares about her experiences in Croatia.

PAST MEDICAL HISTORY

She has a history of needing a hysteroscopy for dysmenorrhoea.

PSYCHIATRIC IMPAIRMENT RATING

Ms Vera NIKOLOVIC

Psychiatric Diagnosis	
Psychiatric treatment	

Category	Class	Reason for decision
Self Care and Personal Hygiene		
Social and Recreational Activities		
Travel		
Social Functioning		
Concentration, Persistence and Pace		
Adaptation		

Classes in Ascending Order:

Median Class

=

Aggregate Score Impairment:

Total **WPI%**

=

Whole Person Impairment:

%

CASE STUDY 3 – MENTAL AND BEHAVIOURAL DISORDERS

Name:	Mr John FARMER
Date of Birth:	3 August 1960
Date of Accident:	18 November 1999
Date of Assessment:	6 September 2001

BACKGROUND

Mr Farmer is a 41 year old fork lift driver currently living in Northern NSW. His 17 year old son, Jeremy, was killed in an accident on 18 November 1999. His son was living with Mr Farmer, but at the time of the accident was visiting his mother.

Mr Smith received a phone call from a police officer, informing him that his son was killed in a motor vehicle accident. Jeremy was a passenger in a car driven by a friend, who did not hold a driver's licence. The driver was thought to be speeding, when his car left the road and hit a number of trees. Mr Farmer's son was killed instantly.

His brother drove him to collect his son's belongings, and later had to identify his son's body at Hospital. He told Jeremy's mother about the accident and organized the funeral.

Mr Farmer told me the driver spent time in intensive care, but he eventually survived. He faced a number of serious charges relating to the accident that were still to be heard by the courts.

PSYCHIATRIC SEQUELAE

Mr Farmer told me he fell apart after his son's death. He was in a state of shock, and to date had not accepted the loss. He still expected Jeremy to walk back into his house, and he has kept Jeremy's belongings. These included clothing and other personal items. Mr Farmer continues to buy Christmas presents for his son, and to set the dinner table for him.

His sleep deteriorated, and he cannot sleep after 1 a.m. His appetite has decreased, but his weight remains stable. He rarely prepares meals and if someone else did not cook he "can't be bothered eating". He lacks energy and motivation. He has lost interest in social activities, and he no longer goes out. He did not renew his driver's license. Mr Farmer told me he previously enjoyed fishing, driving, going to restaurants, pubs and cinemas. He has given up these activities, saying "*I am like a hermit now*".

Mr Farmer feels depressed and irritable all the time. This had a significant impact on his five year relationship with his girlfriend, Ms Mary Mills. They separated in December 2000 for approximately three months. Mr Farmer told me he and Mary are now trying to make the relationship work.

CURRENT ROUTINE

Mr Farmer wakes at 1 am, and he watches the television. He stares at the wall thinking about Jeremy for periods lasting up to one hour. He tries to remain busy looking after his fiancée's mother's property. He goes fishing at a local river, but he does not enjoy it.

He is unable to read due to poor concentration. He reads up to 10 or 15 minutes before losing interest. His libido was low. Mr Farmer rarely left his house, mainly to attend medical appointments or help his fiancée with shopping and banking. His fiancée accompanies him to his medical appointments.

Mr Farmer did not return to work. He told me his concentration was poor, and he worried about injuring others whilst driving his fork lift. He tried to return to work shortly after his son's death, for a few weeks. He was however unable to continue working and his psychiatrist recommended he should stop.

Mr Farmer moved in December 2000. He thought the move would help, but his symptoms did not change. Mr Farmer continues to visit the cemetery every two months and he find birthdays, Christmas and other anniversaries particularly difficult.

TREATMENT

Mr Farmer was first referred to Dr Paul, a psychiatrist. He was prescribed Zoloft initially, and later was changed to Serzone 300 mg twice daily. He took this until early 2001, when he intentionally took an overdose of Serzone and Mogadon.

After moving, Mr Farmer attended treatment with another psychiatrist, Dr Merry. Treatment consisted of Endep 50 mg three times per day, and Melleril 50 mg three times per day. He continues psychotherapy with Dr Merry to help him adjust to the loss.

PAST PSYCHIATRIC HISTORY

Mr Farmer had no history of mental illness prior to his son's death.

Mr Farmer consumed up to 100 grams of alcohol per day before his son's accident. His consumption escalated after his son died, until the overdose in March 2001. At the time he was drinking four cartons of beer per week, indicating an alcohol consumption of 250 grams of alcohol per day. Mr Farmer told me he cut his drinking down significantly after the overdose.

BACKGROUND HISTORY

Mr Farmer has an unremarkable background history. He completed a plant mechanic's apprenticeship and then began driving forklifts. Mr Farmer had custody of Jeremy since he was 4 years old when he and Jeremy's mother separated.

Mr Farmer essentially raised Jeremy, and had a very close relationship with him. Mr Farmer had a daughter from another relationship, who is now 14 years old. He had little contact with his daughter. Mr Farmer has been in a relationship with over the past five years.

MENTAL STATE EXAMINATION

He was punctual for the appointment, and cooperative with the interview process. No other person attended the interview, although his partner accompanied him to the appointment. His speech was normal in volume and rate, and his thinking was coherent. His emotional expression was restricted in range, and he did not smile. He did not experience abnormal perceptual phenomena, such as visual or auditory hallucinations.

He did not express bizarre or unusual ideas, particularly no persecutory delusions or ideas of reference. He was oriented in time, place and person and his memory was grossly intact.

PSYCHIATRIC IMPAIRMENT RATING

Mr John FARMER

Psychiatric Diagnosis	
Psychiatric treatment	

Category	Class	Reason for decision
Self Care and Personal Hygiene		
Social and Recreational Activities		
Travel		
Social Functioning		
Concentration, Persistence and Pace		
Adaptation		

Classes in Ascending Order:

Median Class

=

Aggregate Score Impairment:

Total **WPI%**

=

Whole Person Impairment:

%