Reference Determination Content

Example document — fictitious patient. A suggested draft determination prepared by the Veterans Health Centre from the matching example Diagnostic Assessment, to show how a DVA delegate could determine the claim. Names, dates, service details and clinicians are invented. It is not a decision of the Department of Veterans' Affairs.

Obstructive Sleep Apnoea

Evidence

The evidence that I have considered in making this decision includes:

- Formal Claim with supporting statements;
- A Statement of your Service from the Department of Defence;
- Copies of your Service Medical Records.
- A Diagnostic Assessment by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 12 March 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 12 March 2025;
- A trauma admission and CT report by Role 3 hospital, Afghanistan, dated 4 August 2010;
- A specialist letter by the infectious diseases physician, dated 6 December 2010;
- A psychiatric assessment by the consultant psychiatrist, dated 14 January 2011;
- CT paranasal sinuses by the radiologist, dated 12 March 2011;
- A periodic health examination by the medical officer, Garrison health centre, dated 30 July 2013;
- A pain medicine consultation by the pain specialist, dated 10 October 2013;
- An echocardiogram and cardiology consultation by the cardiologist, dated 5 May 2014;
- An MRI pituitary and endocrinology consultation by the endocrinologist, dated 5 May 2014;
- A renal medicine consultation by the renal physician, dated 2 June 2014;
- An outpatient health record by the medical officer, Garrison health centre, dated 22 July 2014;
- A diagnostic polysomnography report by the sleep physician, dated 8 February 2016;
- A specialist consultation by the respiratory and sleep physician, dated 11 April 2016;
- A repeat polysomnography report by the sleep physician, dated 5 November 2018;
- A specialist follow-up by the respiratory and sleep physician, dated 19 November 2018.

Your service

I have identified that you have the following service:
Australian Defence Force service between :

17 January 2003 and 22 August 2019

Obstructive Sleep Apnoea

You have stated that your condition was caused by:

- *having heart failure at the time of the clinical onset of sleep apnoea*
- *having a central nervous system lesion or disorder from the specified list of central nervous system lesions or disorders at the time of the clinical onset of sleep apnoea*
- *having autonomic neuropathy at the time of the clinical onset of sleep apnoea*
- *having chronic renal failure at the time of the clinical onset of sleep apnoea*
- *having a neuromuscular disease affecting the diaphragm, other respiratory muscles or upper airway muscles at the time of the clinical onset of sleep apnoea*
- *having acromegaly at the time of the clinical onset of sleep apnoea*
- *for obstructive sleep apnoea only: having hypothyroidism, including Hashimoto thyroiditis that has resulted in hypothyroidism, at the time of the clinical onset of obstructive sleep apnoea*
- *for obstructive sleep apnoea only: having chronic obstruction or chronic narrowing of the upper airway at the time of the clinical onset of obstructive sleep apnoea*
- *for obstructive sleep apnoea only: being obese at the time of the clinical onset of obstructive sleep apnoea*
- *Being in a supine position when sleeping for at least the 6 months before the clinical onset of obstructive sleep apnoea*
- *for central sleep apnoea only, taking a long-acting opioid at an average daily morphine equivalent dose of at least 120 milligrams for at least the 2 months before the clinical onset of central sleep apnoea*

Diagnosis: Obstructive Sleep Apnoea

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 12 March 2025, and is supported by a diagnostic polysomnography report by the sleep physician, dated 8 February 2016.

I am satisfied this is the appropriate diagnosis.
In determining your claim for this condition, I have applied the SOP:

Statement of Principles concerning Sleep Apnoea (Balance of Probabilities) (No. 69 of 2022)

which sets out the factors that can connect the condition with service.

I am satisfied that you have met the following factor:

- *having heart failure at the time of the clinical onset of sleep apnoea*
- *having a central nervous system lesion or disorder from the specified list of central nervous system lesions or disorders at the time of the clinical onset of sleep apnoea*
- *having autonomic neuropathy at the time of the clinical onset of sleep apnoea*
- *having chronic renal failure at the time of the clinical onset of sleep apnoea*
- *having a neuromuscular disease affecting the diaphragm, other respiratory muscles or upper airway muscles at the time of the clinical onset of sleep apnoea*
- *having acromegaly at the time of the clinical onset of sleep apnoea*
- *for obstructive sleep apnoea only: having hypothyroidism, including Hashimoto thyroiditis that has resulted in hypothyroidism, at the time of the clinical onset of obstructive sleep apnoea*
- *for obstructive sleep apnoea only: having chronic obstruction or chronic narrowing of the upper airway at the time of the clinical onset of obstructive sleep apnoea*
- *for obstructive sleep apnoea only: being obese at the time of the clinical onset of obstructive sleep apnoea*
- *Being in a supine position when sleeping for at least the 6 months before the clinical onset of obstructive sleep apnoea*
- *for central sleep apnoea only, taking a long-acting opioid at an average daily morphine equivalent dose of at least 120 milligrams for at least the 2 months before the clinical onset of central sleep apnoea*

I have noted your contention as to the cause of this condition. The available evidence indicates, I have noted your contention to the cause of your condition. Your service medical records indicate that you presented to the health facility with loud habitual snoring, witnessed pauses in breathing, choking arousals, unrefreshing sleep, morning headaches and excessive daytime sleepiness, including falling asleep during briefings on 22 July 2014.

The diagnosis was confirmed by diagnostic polysomnography on 8 February 2016, which showed an apnoea-hypopnoea index of 27 events per hour with predominantly obstructive events despite continuing respiratory effort, a central apnoea index of 6, positional worsening when supine and oxygen desaturation to 84 per cent. This meets the Statement of Principles definition of obstructive sleep apnoea, and the central events meet the definition of central sleep apnoea.

This has then led to further investigations and the diagnosis of your condition of *Obstructive Sleep Apnoea*. I have accepted your condition of *Obstructive Sleep Apnoea*.

Having considered your service records and the available medical evidence, I am satisfied the SOP is met and that this condition is related to your peacetime service.

I have therefore accepted that this condition is related to your service with effect from 15 July 2014.

Obstructive Sleep Apnoea (Worsening)

Evidence

The evidence that I have considered in making this decision includes:

- Formal Claim with supporting statements;
- A Statement of your Service from the Department of Defence;
- Copies of your Service Medical Records.
- A Diagnostic Assessment by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 12 March 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 12 March 2025;
- A trauma admission and CT report by Role 3 hospital, Afghanistan, dated 4 August 2010;
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- An MRI pituitary and endocrinology consultation by the endocrinologist, dated 5 May 2014;
- A renal medicine consultation by the renal physician, dated 2 June 2014;
- An outpatient health record by the medical officer, Garrison health centre, dated 22 July 2014;
- A diagnostic polysomnography report by the sleep physician, dated 8 February 2016;
- A specialist consultation by the respiratory and sleep physician, dated 11 April 2016;
- A repeat polysomnography report by the sleep physician, dated 5 November 2018;
- A specialist follow-up by the respiratory and sleep physician, dated 19 November 2018.

Your service

I have identified that you have the following service:
Australian Defence Force service between :

17 January 2003 and 22 August 2019

Obstructive Sleep Apnoea (Worsening)

You have stated that the worsening of your condition was caused by:

- *having heart failure at the time of the clinical worsening of sleep apnoea*
- *having a central nervous system lesion or disorder from the specified list of central nervous system lesions or disorders at the time of the clinical worsening of sleep apnoea*
- *having autonomic neuropathy at the time of the clinical worsening of sleep apnoea*
- *having chronic renal failure at the time of the clinical worsening of sleep apnoea*
- *having a neuromuscular disease affecting the diaphragm, other respiratory muscles or upper airway muscles at the time of the clinical worsening of sleep apnoea*
- *having acromegaly at the time of the clinical worsening of sleep apnoea*
- *consuming an average of at least 30 grams of alcohol per day for at least the 6 months before the clinical worsening of sleep apnoea*
- *for obstructive sleep apnoea only: having hypothyroidism, including Hashimoto thyroiditis that has resulted in hypothyroidism, at the time of the clinical worsening of obstructive sleep apnoea*
- *for obstructive sleep apnoea only: having chronic obstruction or chronic narrowing of the upper airway at the time of the clinical worsening of obstructive sleep apnoea*
- *for obstructive sleep apnoea only: being obese at the time of the clinical worsening of obstructive sleep apnoea*
- *Being in a supine position when sleeping for at least the 6 months before the clinical worsening of obstructive sleep apnoea*
- *for central sleep apnoea only, taking a long-acting opioid at an average daily morphine equivalent dose of at least 120 milligrams for at least the 2 months before the clinical worsening of central sleep apnoea*
- *inability to obtain appropriate clinical management for sleep apnoea*

Diagnosis: Obstructive Sleep Apnoea (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 12 March 2025, and is supported by a diagnostic polysomnography report by the sleep physician, dated 8 February 2016.

I am satisfied this is the appropriate diagnosis.
In determining your claim for this condition, I have applied the SOP:

Statement of Principles concerning Sleep Apnoea (Balance of Probabilities) (No. 69 of 2022)

which sets out the factors that can connect the condition with service.

I am satisfied that you have met the following factor:

- *having heart failure at the time of the clinical worsening of sleep apnoea*
- *having a central nervous system lesion or disorder from the specified list of central nervous system lesions or disorders at the time of the clinical worsening of sleep apnoea*
- *having autonomic neuropathy at the time of the clinical worsening of sleep apnoea*

- *having chronic renal failure at the time of the clinical worsening of sleep apnoea*
- *having a neuromuscular disease affecting the diaphragm, other respiratory muscles or upper airway muscles at the time of the clinical worsening of sleep apnoea*
- *having acromegaly at the time of the clinical worsening of sleep apnoea*
- *consuming an average of at least 30 grams of alcohol per day for at least the 6 months before the clinical worsening of sleep apnoea*
- *for obstructive sleep apnoea only: having hypothyroidism, including Hashimoto thyroiditis that has resulted in hypothyroidism, at the time of the clinical worsening of obstructive sleep apnoea*
- *for obstructive sleep apnoea only: having chronic obstruction or chronic narrowing of the upper airway at the time of the clinical worsening of obstructive sleep apnoea*
- *for obstructive sleep apnoea only: being obese at the time of the clinical worsening of obstructive sleep apnoea*
- *Being in a supine position when sleeping for at least the 6 months before the clinical worsening of obstructive sleep apnoea*
- *for central sleep apnoea only, taking a long-acting opioid at an average daily morphine equivalent dose of at least 120 milligrams for at least the 2 months before the clinical worsening of central sleep apnoea*
- *inability to obtain appropriate clinical management for sleep apnoea*

I have noted your contention as to the cause of this condition. The available evidence indicates, I have noted your contention to the cause of your condition. Your service medical records indicate that you presented to the health facility with loud habitual snoring, witnessed pauses in breathing, choking arousals, unrefreshing sleep, morning headaches and excessive daytime sleepiness, including falling asleep during briefings on 22 July 2014.

The diagnosis was confirmed by diagnostic polysomnography on 8 February 2016, which showed an apnoea-hypopnoea index of 27 events per hour with predominantly obstructive events despite continuing respiratory effort, a central apnoea index of 6, positional worsening when supine and oxygen desaturation to 84 per cent. This meets the Statement of Principles definition of obstructive sleep apnoea, and the central events meet the definition of central sleep apnoea.

After the condition arose, it was worsened during your service. Heart failure with reduced ejection fraction persisted after onset and was present when the sleep apnoea worsened in 2018, with the apnoea-hypopnoea index rising from 27 to 52 events per hour on repeat polysomnography on 5 November 2018. The moderate traumatic brain injury of 2010 remained present when the sleep apnoea worsened in November 2018. Cardiovascular autonomic neuropathy persisted and was present at the documented worsening in November 2018. You remained on haemodialysis for chronic renal failure when the sleep apnoea worsened in November 2018, and fluid overload between dialysis sessions was documented during your deployment. Residual diaphragmatic weakness from critical illness neuromyopathy was present when the sleep apnoea worsened in November 2018. Acromegaly remained biochemically

active, with a raised IGF-1 in October 2018, when the sleep apnoea worsened. You drank an average of about 50 grams of alcohol a day throughout 2018, including the 6 months before the worsening, from 5 May 2018 to 5 November 2018. Thyroid function tests in October 2018 showed persisting hypothyroidism, under-replaced while you were deployed, at the time the obstructive sleep apnoea worsened. The fixed septal deviation and turbinate hypertrophy persisted at the worsening in November 2018, and nasal obstruction was recorded as making CPAP harder to tolerate. Your BMI was 34.0 on 19 November 2018, when the worsening was documented. You continued to sleep supine because of your lumbar injury throughout the 6 months before the worsening, from 5 May 2018 to 5 November 2018, including in deployed accommodation. Controlled-release oxycodone at 180 mg oral morphine equivalent per day continued throughout the 2 months before the worsening, from 5 September 2018 to 5 November 2018, and the central apnoea index rose to 11 on the repeat study. During your deployment from February to September 2018 you could not use your CPAP machine because power in your accommodation was rationed and unreliable, and no alternative was provided.

This has then led to further investigations and the diagnosis of your condition of *Obstructive Sleep Apnoea (Worsening)*. I have accepted your condition of *Obstructive Sleep Apnoea (Worsening)*.

Having considered your service records and the available medical evidence, I am satisfied the SOP is met and that the worsening of this condition is related to your peacetime service.

I have therefore accepted that the worsening of this condition is related to your service with effect from 5 November 2018.

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