# WORKERS COMPENSATION COMMISSION

## STATEMENT OF REASONS FOR DECISION OF THE APPEAL PANEL IN RELATION TO A MEDICAL DISPUTE

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| **Matter Number:** | **M1-2394/19** |
| **Appellant:** | **Emma Polly Bennett** |
| **Respondent:** | **Secretary, Department of Education** |
| **Date of Decision:** | **4 February 2020** |
| **Citation:** | **[2020] NSWWCCMA 17** |

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| **Appeal Panel:** | |
| **Arbitrator:** | **Ross Bell** |
| **Approved Medical Specialist:** | **Dr Robin Fitzsimons** |
| **Approved Medical Specialist:** | **Dr Mark Burns** |

### BACKGROUND TO THE APPLICATION TO APPEAL

1. On 4 October 2019 Emma Polly Bennett lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Sophia Lahz, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 9 September 2019.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - availability of additional relevant information (but only if the additional information was not available to, and could not reasonably have been obtained by, the appellant before the medical assessment appealed against) (section 327(3)(b));
    - the assessment was made on the basis of incorrect criteria (section 327(3)(c));
    - the MAC contains a demonstrable error (section 327(3)(d)).

3. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground(s) of appeal on which the appeal is made.

4. The Workers compensation medical dispute assessment guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the Workers compensation medical dispute assessment guidelines.

5. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* ed 1 April 2016 (the Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

### RELEVANT FACTUAL BACKGROUND

6. It is convenient to extract the history reported by the AMS at Part 4 of the MAC,

> "Brief history of the incident/onset of symptoms and of subsequent related events, including treatment:

Ms Bennett was pleasant and cooperative during the interview and examination although I found her a slow, hesitant disorganised historian, notwithstanding the many years which have passed since the subject work injury/motor accident. It was difficult to obtain a well sequenced history so below, I attempt to provide the “big picture” of the history since the work injury.

The worker was involved in motor accident shortly after leaving her workplace in September 2001. She remembers the period shortly before she drove out from the school. She has no memory of the accident itself. Her former husband apparently came to the scene although she does not recall this. The ambulance came although she does not recall being transferred to hospital. She was initially at West Wyalong Hospital and then sent to Wagga Base Hospital with spinal and head injuries where she remained for the next ten days. Her first recollection took place when she saw her brother at hospital about two hours after the accident. She has “islands” of memory whilst at Wagga Hospital — she has a memory of excruciating head pain (due to the neck collar) during the inter-hospital transfer from West Wyalong to Wagga. She also remembered noticing that that her right knee had a film dressing on it whilst still hospitalised (due to a large laceration). Otherwise, she said that the time in hospital was a “blank”. She referred to feelings in hospital of “disorientation”, “detachment” and “not caring”.

I asked the worker’s father how Ms Bennett appeared in the hospital. He reported that there was very severe pain, and that she had been very anxious. She recognised family, he said although she confused the names of the hospital staff looking after her, and had difficulties following instructions.

X-rays detected several fractures in the neck, and according to Ms Bennett, there were also fractures in the lower thoracic spine (I notice that the formal radiology reports suggest that there was developmental wedging in the thoracolumbar region as opposed fractures.)

The neck injury was managed conservatively in a collar for many weeks after the accident. There was some bruising/contusion of the cervical spinal cord indicated on scans, and she has been left with unpleasant burning, itchy sensations in specific areas of the arms and legs, discussed further below. There is also weakness particularly of the right side of the body. The right arm and leg have been considerably more affected by sensory change than the left although the left side is also not 100% normal due to the incomplete spinal cord injury.

Neither she nor her father were aware of whether the Westmead post-traumatic amnesia (PTA) scale had been administered during the hospital admission (to gauge the severity of the traumatic brain injury). I described this testing (which utilizes orientation questions and picture cards) to them although they had no idea. The brain scan reports which I have viewed did not refer to any trauma-related abnormalities. Her father then remarked that the family had little idea what went on at Wagga Hospital, and the worker added that it was only when her parents arranged for her to consult a few Sydney-based spinal, brain and pain specialists who “knew what they were doing” that she became clearer about the causation of her ongoing difficulties.
Ms Bennett emphasised that she felt the local doctors did not appreciate the severity of her injuries from the accident, particularly the effects of pain, and that her difficulties were frequently underestimated (put down to anxiety) until she sought specialist help at RNSH in Sydney about two years later. During that period, she was a shadow of her former self due to severe pain and cognitive difficulties.

Her behaviour and function deteriorated so markedly after the accident, that her former husband could not cope, and left the marriage about a year later. Ms Bennett had been needing help with personal care, was extremely forgetful and asking the same questions repetitively. There are two children from that marriage.

Ms Bennett said that she did receive allied health brain injury rehabilitation interventions at Takarri in Albury. These mostly targeted her cognition given the memory problems and her general disarray with planning and organisation. Since the accident, she has also suffered from marked fatigue which has never improved. There have been a series of neuropsychological assessments since the motor accident, most recently in 2004 although of interest, these reports do not refer to objective measures of brain injury severity such as either PTA scoring or GCS.

In Sydney, Ms Bennett saw Dr Bowman at SVH regarding the effects of the neck injury. Various medications were trialled for pain.

In about 2004, Ms Bennett attended the ADAPT pain management programme at RNSH learned that there was no quick fix/cure for her pain - it would always be there and she just had to learn how to deal with it.

The main sites of pain ongoing have been the neck, right arm, right leg, left flank and exercises taught her during this comprehensive pain management programme medications which she had been taking after the accident for pain/mood were tapered and ceased. She also remarked that she prefers to watch a TV programme or partake of an activity, rather than take a pill when feeling upset or else there is particularly severe pain. She is not on any prescription drugs for pain.

By late 2005, Ms Bennett had returned to work in a very well supported work environment where jobs were tailored to her specific requirements. Since the accident and ongoing, Ms Bennett has prioritized employment above all other matters in her life. In other words, she has been living to work. If she participates in too many different activities e.g. riding for the disabled, working, she becomes too fatigued and will eliminate other activities in order to remain at work. She has required considerable support (both emotional and practical) from her parents and sister since the accident. This has taken the form of meal preparation, general help around the house, personal care at times, and transportation. Ms Bennett is able to drive (having passed an assessment) although due to her difficulties she only drives short distances around town.

She continued to receive rehabilitative interventions until 2012 when she was found to have reached MMI. Consequently, treatment funded by the insurer ceased.

Ms Bennett's current medical certificate indicates that she should not lift, nor work more than 15-minute drive from home. She has been deemed medically fit to work eight hours per week."

**PRELIMINARY REVIEW**

7. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the WorkCover Medical Assessment Guidelines.

8. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination for the reasons given below.

**EVIDENCE**

**Documentary evidence**

9. The Appeal Panel has before it all the documents that were sent to the AMS for the original medical assessment and has taken them into account in making this determination.

**Fresh Evidence**

10. The appellant seeks to have material introduced to the appeal under s 328(3) of the 1998 Act, which provides that evidence that is fresh evidence or evidence in additional to or in substitution for the evidence received in relation to a medical assessment appealed against may not be given on an appeal by a party unless the evidence was not available to the party before the medical assessment and could not reasonably have been obtained by the party before that medical assessment.

11. The material was annexed to Applications to Admit Late Documents filed in the proceedings before the assessment by the AMS. It is apparent to the Panel that these documents do not constitute material under s 328(3) of the 1998 Act but are documents that should have been before the AMS. It is not clear whether the documents were in fact before the AMS, and the Panel has taken them into account. They will be referred to in the discussion below.

**Medical Assessment Certificate**

12. The parts of the medical certificate given by the AMS are set out, where relevant, in the body of this decision.

**SUBMISSIONS**

13. Both parties made written submissions. They are not repeated in full but have been considered by the Appeal Panel.

14. The appeal relates only to the MAC of Dr Sophia Lahz, one of the three MACs prepared for the assessment overall, and is against the assessment by Dr Lahz of brain damage, neck, back, left arm at or above the elbow, and right arm at or above the elbow on the Table of Disabilities.

**Appellant**

15. In summary, the appellant submits that the AMS has erred in basing the assessment of brain damage on incorrect criteria. The AMS should have taken account of subjective signs including the injured worker's account of symptoms and signs as indicated by the relevant case law. The AMS has wrongly used criteria to assess whether the brain injury was of enough severity to cause the symptoms complained of. The AMS refers to characteristics including a GCS of 8 or less and a PTA duration of at least 4 weeks to result in a high level of permanent brain damage, which involves incorrect criteria. The AMS has also committed a demonstrable error for the same reasons.

16. The AMS has incorrectly calculated the impairment for all body parts which were not calculated according to the relevant case law and the assessments of Dr Stening and Dr Cochrane.

**Respondent**

17. The respondent submits, in summary, that the AMS did not err in the assessment or base the assessment on incorrect criteria.

18. There is no basis for the appellant's objection to the credentials of the AMS, and no objection was taken after the referral of the assessment to Dr Lahz before the assessment

19. The AMS was entitled to balance the evidence considered in assessing impairment. There are no written guidelines on how loss under the Table of Disabilities is to be measured and

the task is one for the application of clinical judgement and discretion. The appellant is seeking to cavil at matters of clinical judgement.[1]

20. The MAC complies with the Workers Compensation Medical Dispute Guidelines, at Part 4.2. The AMS has conducted a proper and thorough assessment as demonstrated by the request by the AMS for information including hospital and contemporaneous medical records, to which she referred in her assessment.

21. Contrary to the appellant's submissions, the assessment is not indicative of a 100% reduction of the impairment assessed, because the AMS accepted there was a compensable injury to the brain; considered that the injury was minor and had resolved; and this was the basis for the assessment of 0% impairment which was explained in terms of the evidence and findings on examination.

22. There are no submissions as to how the orthopaedic assessments were in error, other than that they should be re-assessed given the errors in the brain damage assessment. The orthopaedic assessments were correct.

**FINDINGS AND REASONS**

23. The procedures on appeal are contained in s 328 of the 1998 Act. The appeal is to be by way of review of the original medical assessment, but the review is limited to the grounds of appeal on which the appeal is made.

24. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 the Court of Appeal held that the Appeal Panel is obliged to give reasons. Where there are disputes of fact it may be necessary to refer to evidence or other material on which findings are based, but the extent to which this is necessary will vary from case to case. Where more than one conclusion is open, it will be necessary to explain why one conclusion is preferred. On the other hand, the reasons need not be extensive or provide a detailed explanation of the criteria applied by the medical professionals in reaching a professional judgement.

**Assessment of brain damage**

25. In *Mahenthirarasa v State Rail Authority of New South Wales & Ors* [2007] NSWSC 22 (*Mahenthirarasa*), the Court said: "A demonstrable error would essentially be an error for which there is no information or material to support the finding made – rather than a difference of opinion.".

26. In *Pitsonis* the Court said,

> "Those dependent on the applicant showing that the doctor failed to record or to record correctly things she had told him face a double difficulty. They are not demonstrable on the face of the Certificate. And they seek, in effect to cavil at matters of clinical judgment in that matters unrecorded are likely to be matters on which the specialist placed no weight. The same can be said about factual matters recorded in one part of the Certificate that did not translate into the decision favourable to the applicant now contended for."

27. The Panel notes that the AMS very carefully considered the diagnosis throughout the MAC. The history of symptoms has been meticulously explored and recorded. This includes Ms Bennett's own account of her symptoms. Contrary to the submissions for the appellant this process did not involve the use of incorrect assessment criteria to establish the correct diagnosis.

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[1] *Marina Pitsonis v Registrar Workers Compensation Commission & Anor* [2008] NSW CA 88 (*Pitsonis*)

28. Apart from the history extracted above for background, under "present symptoms" the AMS takes a comprehensive and detailed history.

29. The AMS refers in detail to the reports before her and discusses the additional documents she called for from the time of injury including the ambulance report and acute hospital records. The AMS considers all the material in depth, and at Part 10.a. she explains how her conclusions were reached. She notes,

> "There is little evidence that long-term deficits are attributable to mild traumatic brain injury more than 12 months post-injury. Most people with a single mild traumatic brain injury do not have long-term cognitive deficits although there are a small number of individuals who do not follow this typical recovery trajectory and whose persistent symptoms are believed to have other contributors not traumatic brain injury, including chronic pain, psychological distress, depression, anxiety and persistent sleep disturbance. I believe the latter issues are relevant in the case of Ms Bennett."

30. The submissions for Mr Bennett imply that the AMS should have assessed symptoms she finds to be unrelated to a permanent brain injury. It is also submitted that the AMS "reduced" the assessment by 100%. Neither of these submissions can be accepted. The AMS did assess the permanent brain damage, at 0%. The explanation by the AMS at Part 10 is clear as to the basis of her findings. The evidence does not support a finding of anything greater than a mild brain injury, the symptoms of which have resolved, leaving only psychological symptoms unrelated to any impairment from the traumatic brain injury. In the opinion of the AMS, these remaining psychological symptoms arise from elements including pain, distress, depression and sleep disturbance due to the physical injuries, not the traumatic brain injury.

31. The importance of the exercise of clinical judgement by an AMS in the process of assessment was confirmed by the Supreme Court in *Glenn William Parker v Select Civil Pty Limited* [2018] NSWSC 140 (*Parker*),

> "In *Ferguson v State of New South Wales* [2017] NSWSC 887 at [23], Campbell J cited with approval *NSW Police Force v Daniel Wark* [2012] NSWWCCMA 36 ("*Wark*"), where it is stated at [33]:
>
> > '…the pre-eminence of the clinical observations cannot be understated. The judgment as to the significance or otherwise of the matters raised in the consultation is very much a matter for assessment by the clinician with the responsibility of conducting his/her enquiries with the applicant face to face. …'

32. The appellant's list of authorities for assessments under the Table of Disabilities is, according to the submissions, support for the principle that loss of use under the Table is not only concerned with objective signs but also subjective elements including complaints of the worker. The appellant submits that the AMS has contravened these authorities because she did not take account of Ms Bennett's subjective reporting of the dysfunction arising from her brain damage.

33. On the contrary, as noted above, the AMS took a detailed history of symptoms from Ms Bennett. Where the findings of the AMS differ from Ms Bennett's opinion is in the diagnosis of those symptoms. The AMS does not dismiss the symptoms but does not see them as arising from permanent brain damage. That Ms Bennett attributes her psychological symptoms to brain damage is not a proper basis of appeal, as is clear from the cases discussed above. A difference of opinion is not enough in itself; it was the AMS's role to apply her clinical judgement to the evidence and findings on examination. The AMS has done this. This submission must be rejected.

34. Also rejected is the submission that the AMS required Ms Bennett to "prove" that a severe traumatic brain injury had occurred. As can be seen from the passage at Part 10.a., the AMS is explaining that the presence of abnormalities is insufficient to establish medically that brain injury is responsible,

> "Thus, the demonstration of neuropsychological abnormalities in the worker does not "prove" that a severe traumatic brain injury has occurred. The available neuropsychological assessments of Ms Bennett refer to a brief duration of PTA (under 24 hours) based on the worker's self-report. They detail various cognitive difficulties, which are not in dispute - what is in dispute is whether these difficulties result from traumatic brain injury/brain damage occurring in the accident. The evidence in the documentation indicates that they are not given the lack of objective findings to support a traumatic brain injury of sufficient severity to cause the symptoms and disabilities of which the worker complains."

35. This process is a matter for the AMS to determine on the evidence, as she explains. This is part of the legislative role of the AMS and does not place on Ms Bennett any onus to prove a severe traumatic brain injury. The use of inverted commas by the AMS indicates the term is being used in a general rather than legal sense.

36. The Panel notes that the AMS has sought medical records in addition to those relied on by the parties to assist her with the diagnosis and assessment. These documents were not before the assessors relied on by the parties. Given the relevance of the records, this weakens the value of those opinions, although it is not up to the AMS to prefer any of the reports relied on over others.

37. This raises the issue of Dr Cochrane's report of 30 July 2019. It is unclear whether Dr Cochrane's report was before the AMS, but this is of no consequence because the Panel is satisfied it would not have altered the assessment in any way. Dr Cochrane took a similar history to that of other assessors. He concludes,

> "… the fact that the motor vehicle accident resulted in significant cervical injury with crush fractures of C4, C5, and C6, that a closed head injury occurred and this is likely, on the balance of probability, to be the cause of current neurocognitive dysfunction."

38. The problem is that without the contemporaneous documents called for by the AMS being before Dr Cochrane his opinion is based on an incomplete medical history. Although his assessment is lower Dr Cochrane generally agrees with Dr Stening, but the opinions and assessments of both are rendered unreliable because neither had the contemporaneous documents called for by Dr Lahz which have considerable significance for diagnosis and assessment.

39. The AMS is the only assessor to have the complete medical history and she explains in detail her diagnosis and assessment. The early history, including observational records immediately after the injury, informs the AMS's findings as to the nature of the traumatic brain injury. She finds it to have been mild, leaving no permanent impairment with the various psychological symptoms suffered since the accident to arise from what is essentially a psychological injury secondary to the physical injuries.

40. The AMS at Part 7 when reviewing the medical reports notes references in some of the earlier reports to psychological issues. She also notes a normal CT of the brain (in the absence of an MRI).

41. The Panel is of the view that the findings of the AMS on diagnosis and the assessment of brain damage are consistent with the evidence overall and were open to her.

**Assessment of the back; neck; left arm at or above the elbow; right arm at or above the elbow**

42. The Panel notes that it is unclear whether the report of Dr Machart dated 30 July 2019 was before the AMS. In the Panel's view the report of Dr Machart would not have made any difference to the assessments of the AMS. Given that there is no proper ground of appeal against the body parts assessed by Dr Machart, it need not be considered further.

43. The Panel notes that the report of Dr Howison dated 10 July 2019 is not relevant to this appeal.

44. The appellant submits that the assessment of the above body parts is incorrect because the assessment of the brain injury is incorrect. No submission is made as to any specific error in these assessments. This is not a proper ground of appeal.

45. The Panel discerns no demonstrable error on the face of the Certificate and the assessments are not based on incorrect criteria.

**Findings**

46. For the above reasons, the Appeal Panel has determined that the MAC issued on 9 September 2019 is confirmed.

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

A Vermeulen

**Anneke Vermeulen**
**Dispute Services Officer**
As delegate of the Registrar