WORKERS COMPENSATION COMMISSION

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

Matter No:	**M2-2971/19**
Appellant	**Steven Frank Thomas**
Respondent:	**Secretary, Department of Education**
Date of Decision:	**10 February 2020**
Citation:	**[2020] NSWWCCMA 19**

Appeal Panel:	
Arbitrator:	**Mr John Harris**
Approved Medical Specialist:	**Dr Sophia Lahz**
Approved Medical Specialist:	**Dr Robin Fitzsimons**

BACKGROUND TO THE APPLICATION TO APPEAL

1. Mr Steven Thomas (the appellant) suffered injury on 19 October 2011 in the course of his employment as a school teacher with the respondent. The appellant was struck on the right side of the head by a high velocity soccer ball.

2. A claim for compensation pursuant to s 66 *Workers Compensation Act 1987* (the 1987 Act) was made by letter dated 17 January 2019.[1] The s 66 claim was based on injury to "ear, nose and throat", "hearing" and "nervous" systems. The referral to the assessing AMS in the subject Appeal was in relation to "central (and) peripheral nervous system, vestibular injury, hearing loss".

3. The respondent failed to respond to the claim. The appellant then commenced proceedings in the Commission seeking permanent impairment compensation in accordance with the letter of claim.

4. The assessment of whole person impairment (WPI) was then referred by the Registrar to Dr Ross Mellick, an Approved Medical Specialist (AMS), who examined the appellant and provided the Medical Assessment Certificate dated 15 October 2019 (MAC).

5. The appellant was also examined by Dr Henley Harrison who provided a Medical Assessment Certificate dated 15 October 2019. Dr Harrison assessed the appellant for hearing loss and tinnitus and provided an assessment of 0% WPI.

6. Dr Mellick provided a consolidated medical assessment certificate incorporating the assessment provided by Dr Harrison.

7. The relevant findings made by the AMS pertinent to the various grounds of appeal are set out later in these Reasons.

8. The appellant was assessed as having a 5% WPI for the central nervous system/clinical dementia rating, 0% WPI for the vestibular system and 0% WPI for hearing loss and associated tinnitus.

[1] Application, p 9

9. The assessment of WPI is undertaken in accordance with the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (fourth edition guidelines).[2] The fourth edition guidelines adopt the 5th edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairment* (AMA 5). Where there is any difference between AMA 5 and the fourth edition guidelines, the fourth guidelines prevail.[3]

THE APPEAL

10. On 11 November 2019, the appellant filed an Application to Appeal Against a Medical Assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission).

11. The WorkCover Medical Assessment Guidelines (the Guidelines) set out the practice and procedure in relation to appeals to Medical Appeal Panels under s 327 of the 1998 Act.

12. The appellant claims that the medical assessment should be reviewed on the ground that the MAC contains a demonstrable error and/or the assessment was made on the basis of incorrect criteria within the meaning of s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act).

13. On 20 December 2019, the Registrar's Delegate issued a decision pursuant to s 327(4) of the 1998 Act. The delegate accepted that error had been made out in the MAC provided by Dr Mellick but not in respect of the MAC provided by Dr Harrison. The Delegated stated:

> "I have separately determined the appeal against the MAC of Dr Henley Harrison which concerns hearing loss. That appeal is not to proceed. Although the submissions in this appeal include those going to the assessment of hearing loss, the Panel should ignore those submissions."

14. The Appeal was filed within 28 days of the date of the MAC. The submissions in support of the grounds of appeal are referred to later in these Reasons.

PRELIMINARY REVIEW

15. The Appeal Panel (AP) conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Guidelines. As a result of that preliminary review, the AP determined, for the reasons provided subsequently, that a ground of appeal had been established.

16. The appellant did not request a re-examination by an AMS who is a member of the AP.

17. The respondent did not address this submission. It otherwise submitted that no error had been established.

18. The AP formed the view that a re-examination of the appellant was not required as it could reassess in the absence of re-examination given the medical reports before it.

[2] The 4th edition guidelines are issued pursuant to s 376 of the s 376 of the *Workplace Injury Management and Workers Compensation Act 1998*
[3] Clause 1.1 of the fourth edition guidelines

19. The AP issued the following direction following the preliminary review (the Direction):

> "The Appeal Panel (AP) has held its preliminary conference and determined that there are demonstrable errors with respect to the assessment made by the AMS for the Central/Peripheral Nervous System and Vestibular System. Prior to undertaking a re-assessment, the parties are directed to make submissions on the following issues:
>
> 1. The AP believes that the finding by Dr Tamhane (Application, p 45) of right sided vestibulopathy from the Unterberger's test may constitute objective evidence of vestibular dysfunction entitling the appellant to be assessed under class 2 of Table 11-4 of AMA 5. The Respondent is directed to file and serve submissions by close of business, 24 January 2020 on this issue.
>
> 2. The AP accepts that the finding of 5% whole person impairment (WPI) for the central and peripheral nervous system constitutes a demonstrable error when the MAC contained an assessment of 7% WPI. The appellant is directed to make submissions as to how the appellant satisfies one of the following criteria in paragraph 5.9 of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment*, fourth edition:
>
>   - significant medically verified abnormalities in the Glasgow Coma Scale score;
>   - significant medically verified duration of post-traumatic amnesia;
>   - significant intracranial pathology on CT scan or MRI.
>
> 3. The appellant is directed to file and serve submissions in reply to the respondent's submissions on direction 1 by close of business, 31 January 2020.
>
> 4. The respondent is directed to file and serve submissions in reply to the appellant's submissions on direction 2 by close of business, 31 January 2020."

EVIDENCE

20. The AP has before it all the documents that were sent to the AMS for the original assessment and has referred to portions of the evidence and taken them into account in making this determination.

GROUND OF APPEAL – BRAIN INJURY/CLINICAL DEMENTIA RATING

Submissions

Appellant's submissions

21. The appellant referred to the findings with reference to Table 13-6 of AMA 5 where the AMS stated that the appellant was "7% WPI with no deductions" and to the assessment in the consolidated medical assessment where the AMS included an assessment of 5% and submitted that this "is demonstrably a wrong assessment".

Respondent's submissions

22. The respondent accepted that Dr Mellick has "mis-recorded this impairment but does not concede that this represents a demonstrable error within the meaning" of s 327 of the 1998 Act.[4]

23. The respondent accepted that this was an "obvious error" within the meaning of s 325(3) of the 1998 Act and could be remedied "appropriately and expeditiously" by a replacement medical assessment certificate.

[4] Respondent's submissions, paragraph 15

Reasons

24. The AMS stated:[5]

> "With reference to Table 13-6, Class 1, middle of the range, I find 7% WPI with no deductions."

25. The respondent's concession that this is an obvious error does not mean that it is not a demonstrable error.

26. Section 327(3)(d) provides that the error must be "demonstrable". In *Vannini v Worldwide Demolitions Pty Ltd* (*Vannini*),[6] Gleeson JA observed that, consistent with the observations of Basten JA in *Mahenthirarasa v State Rail Authority of New South Wales,* a "demonstrable error must be apparent in findings of fact or reasoning contained in the medical assessment certificate, although the error may be established in part by reference to materials that were before the approved medical specialist".[7]

27. The translation of a different figure from the findings within the body of the MAC to the Table at the conclusion of the MAC clearly falls within the meaning of a "demonstrable" error as discussed by Gleeson JA in *Vannini*.

28. The respondent suggested that this matter could be rectified by referral back to the AMS. However, the matter has been sent to the AP by the Registrar. The AP has determined later in these Reasons that there is another error requiring correction and the assessment must otherwise be reassessed according to law. In these circumstances it is inappropriate to adopt the procedure suggested by the respondent and have the AMS correct the error pursuant to s 325(3) of the 1998 Act.

29. This ground of appeal is upheld. The matter requires reassessment according to law: *Drosd v Nominal Insurer*[8] (*Drosd*).

GROUND OF APPEAL – VESTIBULAR FUNCTION

Submissions

Appellant's submissions

30. The appellant referred to the findings of the AMS where he found no abnormality with regard to vestibular function on examination and a consideration of the history did not establish an assessable impairment.

31. The appellant referred to paragraph 11.2b of Chapter 11 of AMA 5 which provides that symptoms of disequilibrium may be intermittent and the examiner needs to gauge functioning during episodes with exacerbations. The paragraph stated that disturbances of vestibular function are evidenced by vertigo. It was submitted:

> "The clear import of that [provision] is that it is not necessary for the symptoms to be present when the physical examination is performed by an AMS in order for an impairment to be assessable."

[5] MAC, p 5
[6] [2018] NSWCA 324 (*Vannini*) at [90]
[7] *Vannini* at [86]
[8] [2016] NSWSC 1053

32. The appellant referred to the evidence which established intermittent symptoms of vertigo. That evidence included the appellant's statement, the opinions expressed by Dr McGrath, Dr Tamhane, Dr Teychenne, Dr Keast and the AMS.

33. The appellant noted that paragraph 11.2b of AMA 5 stated that peripheral vestibular disorders are often associated with hearing loss and tinnitus and that the appellant had these disorders.

34. The appellant submitted that the AMS has disregarded the clear history of ongoing symptoms from 2011 to date and the accompanying findings of hearing loss and tinnitus.

35. It was submitted that the history and findings meant that the appellant was appropriately classified as Class 2 of Table 11-4 of AMA 5.

Respondent's submissions

36. The respondent referred to the findings of the AMS and submitted that there was no error in the assessment of vestibular function.

37. The respondent otherwise submitted that in order to be assessed at Class 2 under Table 11-4 of AMA 5 there must be supporting objective findings along with symptoms and signs of vestibular disequilibrium and some impact on the activities of daily living.

38. The respondent submitted that the AMS has exercised his clinical judgment and his assessment was consistent with the opinion expressed by Dr O'Sullivan.

Reasons

39. The findings on examination provided by the AMS were that there was "no nystagmus or disequilibrium induced by head rotation, nor by assuming the seated position from the lying position or because of assuming the standing position from the seated position."[9]

40. The AMS concluded that there was no abnormality with regard to vestibular function on examination and "a consideration of the history does not establish adequate grounds for an assessable impairment of vestibular function".[10]

41. The relevant portion of paragraph 11.2b of AMA 5 relevantly provides:

> "Disturbances of vestibular function are evidenced by vertigo (vestibular disequilibrium)
> ….
> Vertigo may be accompanied by varying degrees of nausea, vomiting, headache, immobility, ataxia and nystagmus. Movement may increase the vertigo and the accompanying signs and symptoms. Peripheral vestibular (labyrinthine) disorders are often associated with hearing loss and tinnitus.
> ….
> Since vestibular disorders are dynamic, assessment of permanent impairment should be based on determination of the person's condition after it is stable. Although symptoms may be intermittent, the examiner needs to gauge functioning during episodes with exacerbations."

42. Given the findings by the AMS, particularly the statement that a consideration of the history does not establish adequate grounds for an assessable impairment, it is necessary to set out the evidence on this issue in some detail.

[9] MAC, p 3
[10] MAC, p 4

43. The appellant stated that he experienced symptoms of vertigo[11] and was referred to Dr Robert McGrath, Neurologist, who noted that since the accident there was "disequilibrium and tinnitus "almost certainly as a result of post-traumatic vestibular injury".[12]

44. Dr McGrath recommended referral to a vestibular centre such as the RPA Balance Clinic. It does not appear that this treatment was undertaken.

45. In 2012, Dr Allan Keast referred to poor balance and right-sided tinnitus.[13]

46. In April 2013, Dr Stephen Pearson, Otolaryngologist, diagnosed vestibular concussion secondary to trauma.[14]

47. Th appellant has consistent complaints of ongoing tinnitus which were assessed and accepted by Dr Henley Harrison. Dr Harrison recorded that the appellant was suffering from tinnitus and balance problems and opined that there was severe tinnitus caused by the injury. Dr Harrison did not assess the vestibular function (even though this most commonly falls within the referral ambit of ENT assessors) and this aspect was referred to Dr Mellick.

48. Dr Teychenne recorded that the appellant has a probable vestibular injury caused by a combination of peripheral and central vestibular deficits.[15] In a supplementary report dated 14 July 2018 the doctor assessed the appellant at 5% WPI due to vestibular disequilibrium.[16]

49. Dr Sharad Tamhane was qualified by the respondent and provided a report dated 10 August 2017.[17] The doctor recorded that the appellant had a mild right-sided vestibulopathy when he undertook an Unterberger's Test.[18]

50. Dr Dudley O'Sullivan was also qualified by the respondent. In a report dated 14 May 2019 the doctor opined:[19]

> "I, in my opinion, do not consider that his vestibular dysfunction relates to the central vestibular structures but to the peripheral vestibular structures, that is a peripheral vestibular dysfunction."

51. In a subsequent report dated 3 July 2019, Dr O'Sullivan recommended that the appellant be seen by an ENT surgeon who specialises in vestibular dysfunction.[20] The doctor stated that he would "not be doing an assessment of WPI with regards to vestibular dysfunction".[21]

52. The respondent's submission[22] that Dr Mellick's assessment of vestibular function was "consistent with the assessment of Dr O'Sullivan" is incorrect.

53. The appellant was assessed by Dr Harrison as having severe tinnitus. As the appellant correctly submitted, paragraph 11.2b of AMA 5 noted that peripheral vestibular disorders are often associated with tinnitus. The appellant undoubtedly has, as Dr Harrison found, tinnitus caused by the employment injury.

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[11] Application, p 2
[12] Application, p 30
[13] Application, p 11
[14] Application, p 22
[15] Application, p 57
[16] Application, p 60
[17] Application, p 44
[18] Application, p 45
[19] Reply, p 7
[20] Reply, p 11
[21] Reply, p 11
[22] Respondent's submissions, paragraph 21

54. This finding is supportive of the appellant's case and consistent with paragraph 11.2b of AMA 5. The respondent made no contrary submissions to this asserted error.

55. The AP is of the view that there has also been an application of incorrect criteria within the meaning of s 327(3)(c) of the 1998 Act: see *Marina Pitsonis v Registrar of the Workers Compensation Commission of New South Wales*[23] applying Basten JA in *Campbelltown City Council v Vegan*[24].

56. The appellant otherwise referred to the terms of paragraph 11.2b which acknowledges that symptoms of disequilibrium may be intermittent and the examiner needs to gauge functioning during episodes with exacerbations. The AP agrees with this submission.

57. The analysis of the medical evidence establishes that the appellant has consistent ongoing problems associated with vestibular dysfunction. The statement by the AMS that "a consideration of the history does not establish adequate grounds for assessment" is contrary to all of the medical evidence which establishes that there is consistent medical opinion supporting the vestibular dysfunction.

58. The only medical evidence referred to by the respondent (Dr O'Sullivan) in its submissions as supporting the AMS actually establishes that the appellant has a peripheral vestibular dysfunction.

59. Consistent with the observations of Gleeson JA in *Vannini*, the AP is also satisfied that a finding by the AMS that a consideration of the history is not supportive of the appellant's claim for vestibular dysfunction is incorrect and amounts to a demonstrable error.

60. In these circumstances it is necessary for the AP to re-assess the impairment of the vestibular system: *Drosd v Nominal Insurer.*[25]

REASSESSMENT

61. The AP previously noted that neither party requested that the appellant be re-examined.

62. For the reasons set out herein, the AP accepts that it can reassess in the absence of a re-examination.

63. The parties filed further written submissions in accordance with the Direction.

Assessment of Brain Injury Impairment

64. In its preliminary review the AP drew the attention of the parties to the requirements of paragraph 5.9 of the fourth edition guidelines which provides:

> "For traumatic brain injury, there should be evidence of a severe impact to the head, or that the injury involved a high-energy impact.
>
> Clinical assessment must include at least one of the following:
>
> - significant medically verified abnormalities in the Glasgow Coma Scale score;
> - significant medically verified duration of post-traumatic amnesia;
> - significant intracranial pathology on CT scan or MRI."

[23] [2008] NSWCA 88 (*Marina Pitsonis*) at [40]-[42], McColl and Bell JJA (as their Honours then were) agreeing
[24] [2006] NSWCA 284 at [94], McColl JA agreeing
[25] [2016] NSWSC 1053

65. In its further submissions the appellant submitted that there was no evidence of any Glasgow Coma cores being recorded and that the MRIs of the brain were "essentially normal".

66. In respect of evidence concerning post-traumatic amnesia the appellant relied on his statement evidence, history recorded of loss of consciousness of three to four seconds by Dr Pearson, Dr McGrath, Dr Tamhane and Dr Teychenne and a reference by Dr Teychenne to amnesia.

67. The respondent agreed that there was no evidence of any Glasgow Coma Scale being recorded nor of any significant intracranial pathology on CT or MRI scan. In relation to whether there was any post-traumatic amnesia, the respondent submitted:

> "[T]here is no contemporaneous medical evidence of a significant medically verified duration of post-traumatic amnesia. The Applicant has referred to evidence of a loss of consciousness which the Respondent submits does not amount to a duration of post-traumatic amnesia. The Respondent relies on the opinion of Dr O'Sullivan who stated there was no period of post-traumatic amnesia as the Appellant recalls immediately when he regained consciousness that he was on his knees (Reply page 8)."

68. The AP accepts the common submissions that there are no significant medically verified abnormalities in the Glasgow Coma Scale score and no significant intracranial pathology on CT scan or MRI.

69. Accordingly, to be assessed for traumatic brain injury, the appellant must have significant medically verified duration of post-traumatic amnesia.

70. In a statement dated 17 June 2019 the appellant stated that the "impact of the ball caused me to lose consciousness for up to 5 seconds".[26] In the claim form completed by the appellant on 1 November 2011 he stated that he was "actually knocked out for a few seconds".[27]

71. In January 2012 Dr Keast recorded a history that the appellant was "knocked out for 3-4 seconds".[28] Dr McGrath in August 2015[29] and Dr Tamhane in August 2017[30] recorded a similar history.

72. Dr Teychenne concluded that the appellant was "unconscious for a few seconds"[31] and that he was "amnesic for three to four seconds after the hit to the head".[32]

73. Dr O'Sullivan referred to paragraph 5.9 of the fourth edition guidelines but incorrectly described the criteria. The doctor accepted that one of the criteria was a significant period of unconsciousness and another was a period of post-traumatic amnesia. The doctor appears to have accepted that there was a significant period of unconsciousness but no post-traumatic amnesia.[33]

74. The AMS accepted that the appellant suffered a head injury on 19 October 2011 "which was associated with a brief break in continuity of recall, for perhaps a half minute".[34] That conclusion is inconsistent with the histories recorded by a number of medical practitioners. We do not accept that history as accurate given the other versions provided by the appellant.

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[26] Application, p 1
[27] Application, p 4
[28] Application, p 11
[29] Application, p 27
[30] Application, p 44
[31] Application, p 51
[32] Application, p 55
[33] Reply, p 8
[34] MAC, p 3

75. In the absence of scan evidence and Glascow Coma score abnormalities, the appellant must establish that there was a "significant medically verified duration of post-traumatic amnesia".

76. Whilst it may be correct that loss of consciousness can translate to post-traumatic amnesia, the time span of 3-4 seconds of suggested loss of consciousness does not constitute "significant medically verified duration of post-traumatic amnesia".

77. The time span is so short that the suggestion of lack of recall for 3-4 seconds raises the query how the person making the assertion knew of loss of consciousness of such limited duration. As a matter of commonsense the period is so short that it is difficult to appreciate how someone could understand they lost consciousness for less than five seconds.

78. A further issue is that satisfaction of the criteria requires "significant medically verified duration". The AP, comprised of two medical specialists, does not accept that the suggested timeframe of less than five seconds is "significant medically verified duration". The clear and accepted context of the requirement that significant post-traumatic amnesia be medically verified is that it should be based on contemporaneous opinion, usually following recurrent daily testing in hospital with a validated instrument such as Westmead PTA Scale or else the Abbreviated Westmead PTA Scale (AWPTAS) which is generally used for persons with an initial GCS of either 14/15 or 15/15.

79. The fact that the appellant can recall events quite soon after the accident is a clear demonstration that *significant* post-traumatic amnesia was not present. Put simply, a self-report of loss of consciousness is not objective evidence of post-traumatic amnesia, it is not medically verified. The short time frame is more consistent with a person being dazed following an impact rather than sustaining post traumatic amnesia. The AP does not accept that the acceptance of the appellant's history by various doctors following the injury satisfies this concept.

80. In these circumstances the AP does not accept that the clinical assessment of the appellant establishes the criteria required in paragraph 5.9 of the fourth edition guidelines for traumatic brain injury. The appellant has not established an essential requirement for assessment of traumatic brain injury.

81. For these reasons the AP assesses 0% WPI for the brain injury.

Assessment of Vestibular Dysfunction Impairment

82. The AP refers to the medical evidence concerning the appellant's vestibular dysfunction set out earlier in these Reasons. In particular, we adopt the reasoning of Dr O'Sullivan that the appellant has symptoms and signs of peripheral vestibular dysfunction. In forming that opinion, we refer to paragraph 11.2b of AMA 5 that peripheral vestibular disorders are often associated with hearing loss and tinnitus. In that respect we adopt the findings of AMS Dr Harrison concerning the appellant's tinnitus.

83. Table 11-4 of AMA 5 requires that the appellant have "supporting objective findings" of vestibular disequilibrium to satisfy Class 2. In that respect, given the respondent's initial written submissions in the Opposition to the Appeal, the parties were directed to comment on whether the finding by Dr Tamhane of right-sided vestibulopathy from the Unterberger's test constituted supporting objective findings.

84. The respondent submitted that Dr Tamhane provided no assessment for tinnitus and made no assessment of the appellant's vestibular dysfunction. Dr Teychenne assessed the appellant's vestibular dysfunction but does not refer to the positive Unterberger's test as objective evidence on which the assessment is made.

85. The respondent referred to Example 11-5 [sic 11-4] of AMA 5 and submitted that the Dix-Hallpike test is not considered objective evidence for the purposes of an assessment pursuant to Table 11-4. The respondent submitted:[35]

> "[T]he Unterberger's test may be analogous to the Dix-Hallpike test referred to in Example 11-5 [sic 11-4], and therefore, would not be considered objective evidence on which to base an assessment pursuant to Table 11-4 of AMA 5."

86. The appellant submitted:

> "So far as the Appellant is aware, Unterberger's test is a test where the patient is requested to march on the spot for approximately 50 or more steps with his arms extended. The results are objective in that they do not depend upon any responses by the patient to questions asked by the examiner. The results depend upon the measurements of the angle of rotation and movements backwards and forwards during the test.
>
> So far as the Appellant is aware, the Dix-Hallpike test is to an extent subjective in that the examiner is dependent upon the patient reporting the experience of vertigo when the manoeuvre is performed.
>
> The Appellant submits that the finding by Dr Tamhane (Application p.45) of right-sided vestibulopathy from the Unterberger's test constitutes objective evidence of vestibular dysfunction entitling him to be assessed under class 2 of the Table 11-4 of AMA 5 (1%-10% WPI).
>
> The Appellant notes that Dr Teychenne assessed him as 5% under that classification."

87. The AP does not necessarily agree with the appellant's description set out above. For example, a positive Hallpike test in which head movements in a specific direction induce short-lived, fatigable nystagmus is an objective clinical finding although not recognised by the example in AMA 5. Nor does the Panel accept that the Unterberger test which is a procedure undertaken with the eyes closed, is usually performed in the manner described above. The Panel further notes that the patient typically deviates to the side of the vestibular lesion during testing.

88. The respondent submitted that Dr Tamhane did not assess tinnitus and vestibular dysfunction and did not state that this was an objective finding.

89. Dr Tamhane opined that the appellant had severe tinnitus in the right ear and mild symptoms of vestibulopathy[36]. Any failure to assess the condition does not detract from Dr Tamhane's findings of the existence of the condition. In the view of the AP, the opinion of Dr Tamhane is supportive of the view that the appellant suffers from vestibular dysfunction.

90. At least two specialists, Dr McGrath[37] and Dr O'Sullivan[38], have recommended treatment at the RPA Balance Clinic (or comparable vestibular medical practice with specialized equipment capable of assessing vestibular function objectively) in order to establish a diagnosis, so that relevant treatment can be initiated. This investigation and treatment has not occurred. The AP has otherwise been unable to discern that the appellant has had recommended investigation and treatment for this condition.

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[35] Respondents' supplementary written submissions, paragraph 6
[36] Application, p 45
[37] Application, p 28
[38] Reply, p 11

91. The AP notes that there are standard forms of vestibular physiotherapy (including Epley manoeuvres) which are used to treat the kind of vestibular dysfunction which commonly occurs secondary to head injury when calcific particles are dislodged into the semi-circular canals of the inner ear.

92. The AP is of the view that the appellant's treatment for the vestibular dysfunction is far from optimal and completely lacking. It endorses the treatment recommendations made by Dr McGrath and Dr O'Sullivan.

93. Clause 1.16 of the fourth edition guidelines provides that where treatment has been inadequate and maximum medical improvement has not been achieved then the assessment should be deferred.

94. It is the firm view of the AP that the appellant's treatment for his vestibular dysfunction has been inadequate and maximum medical improvement for this condition has not been achieved. For these reasons, we have included in the Table a finding to this effect.

95. In these circumstances, we do not decide whether a right-sided vestibulopathy from the Unterberger's test constituted a supporting objective finding.

DECISION

96. For these reasons, the MAC is revoked and a new Medical Assessment Certificate is issued. The new Medical Assessment Certificate is attached to this statement of reasons.

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

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL

MEDICAL ASSESSMENT CERTIFICATE
Injuries received after 1 January 2002

Matter No: **2971/19**
Applicant: **Steven Thomas**
Respondent: **Secretary, Department of Education**

This Certificate is issued pursuant to section 328(5) of the *Workplace Injury Management and Workers Compensation Act 1998.*

The Appeal Panel revokes the combined Medical Assessment Certificate of Dr Mellick and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in fourth edition guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5**	**% WPI**	**WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality (expressed as a fraction)**	**Sub-total/s % WPI (after any deductions in column 6)**
Central Nervous System & Peripheral nervous system	19.10.11	Chapter 5, Paragraphs 5.4 and 5.9	Chapter 13, Tables 13-5 and 13-6	0%	N/A	0%
Vestibular System	19.10.11	Chapter 5	Chapter 11 Paragraph 11.2b and Table 11-4	Not maximum medical improvement due to inadequate treatment	N/A	N/A
Hearing	19.10.11	Chapter 9, pp 43-52, para 9.1 – 9.15	Chapter 11	0%	N/A	0%
Total % WPI (the Combined Table values of all sub-totals)						

John Harris
Arbitrator

Dr Sophia Lahz
Approved Medical Specialist

Dr Robin Fitzsimons
Approved Medical Specialist

10 February 2020

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

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar