WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-1728/19**
Appellant:	**Robert Arch Skyrme**
Respondent:	**Patrick Stevedores Holdings Pty Limited**
Date of Decision:	**15 November 2019**
Citation:	**[2019] NSWWCCMA 168**

Appeal Panel:	
Arbitrator:	**John Wynyard**
Approved Medical Specialist:	**Dr Gregory McGroder**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 5 July 2019 Robert Arch Skyrme (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Drew Dixon, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 7 June 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):

    - the assessment was made on the basis of incorrect criteria,
    - the MAC contains a demonstrable error.

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 WorkCover Medical 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 WorkCover Medical 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). “WPI" is reference to whole person impairment.

RELEVANT FACTUAL BACKGROUND

6. Following the issue of Consent Orders on 8 May 2019, the delegate of the Registrar referred this matter to an AMS for assessment of WPI to the left lower extremity (ankle), right lower extremity (ankle and subtalar joints), and scarring (TEMSKI) caused by injury on 10 December 2014.

7. Mr Skyrme was employed as a stevedore and on 10 December 2014 fell five metres from a straddle container stacking machine. He fell on both feet and ankles sustaining a fracture of his right ankle and a fracture of his distal left tibula and fibular. He had appropriate treatment at St Vincent's Hospital

8. Complications arose, resulting in an extended stay in hospital and a further three months convalescence at Sydney Private Hospital. Mr Skyrme currently suffers pain and stiffness in the right ankle and foot and is conscious of the disfiguring surgical scars to the right ankle and lower leg. He also has a marked limp.

9. The AMS assessed at 10% WPI in relation to the left lower extremity (ankle), 4% WPI in relation to the right lower extremity (ankle and subtalar joints) and 3% in respect to the scarring, giving a combined value total of 17% WPI.

PRELIMINARY REVIEW

10. 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.

11. Mr Skyrme sought a re-examination by a Panel AMS. As we have found there to be a demonstrable error, a re-examination was arranged on 2 October 2019.

EVIDENCE

Documentary evidence

12. 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.

Further medical examination

13. Dr Brian Noll of the Appeal Panel conducted an examination of the worker on 2 October 2019 and reported to the Appeal Panel.

Medical Assessment Certificate

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

SUBMISSIONS

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

FINDINGS AND REASONS

16. 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.

17. 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.

18. There was unanimity between the parties as to the background of the fall issues raised by Mr Skyrme. The respondent agreed that a demonstrable error had occurred with regard to the range of movement certified by the AMS.

19. Mr Skyrme submitted that in relation to the right lower extremity, there were inconsistencies between the recorded measurements for eversion and inversion at paragraphs 5 and 10 of the MAC. It was submitted that those inconsistencies could represent an error of transposition, or equally that the range of motion in paragraph 5 were incorrect and the findings at paragraph 10 were correct.

20. At paragraph 5[1] the AMS said:

> **"There was stiffness of his right ankle with a 10 degree flexion contracture and plantar flexion was 20 or 25 degrees and there was no movement at the subtalar joint. Eversion was 0 degrees and inversion 0 degrees.**
>
> **In the left ankle there was stiffness with dorsi-flexion 0 degrees, plantar flexion 25 degrees and eversion of the subtalar joint was 10 degrees, and inversion 25 degrees."**

21. At paragraph 10 of the MAC[2] the AMS said:

> **"That for the post traumatic stiffness of the left ankle with dorsi flexion 0 degrees, is 3% whole person impairment, and that for the restricted plantar flexion of 20 degrees is 3% whole person impairment, giving a total of 6% whole person impairment.**
>
> **That for no movement at the subtalar joint with eversion 0 degrees and inversion 0 degrees gives a 4% whole person impairment, as the subtalar joint is ankylosed (fused).**
>
> **This gives a total from the Combined Values Chart of 10% whole person impairment for his left ankle and hind foot.**
>
> **That for his right ankle for restricted dorsi-flexion of 10 degrees is 3%.**
> **That for the plantar flexion of 25 degrees is 0% whole person impairment.**
>
> **That for eversion of 10 degrees of the subtalar joint is 1% whole person impairment, and that for inversion of 25 degrees is 0% whole person impairment, giving a total of 4% whole person impairment for the right ankle and subtalar joint."**

22. Mr Skyrme kindly supplied a comparative table with his submissions which we reproduce, having confirmed its accuracy. It can be seen that there is a significant difference in the reporting of the measurements obtained, and there is no alternative for the resolution of this error but to re-examine Mr Skyrme.

23. The respondent conceded that an error had been made and that a re-examination would have to occur.

[1] Appeal papers page
[2] Appeal papers page 25

24. Mr Skyrme's table is as follows:

Right lower extremity	**Finding p.5 MAC**	**Finding p.10 MAC**	**WPI p.10 MAC**
Flexion contracture	10 degrees	10 degrees	3%
Plantar flexion	20 or 25 degrees	25 degrees	0%
Eversion	0 degrees	10 degrees	1%
Inversion	0 degrees	25 degrees	0%

Left lower extremity	**Finding p.5 MAC**	**Finding p.10 MAC**	**WPI p.10 MAC**
Dorsiflexion	0 degrees	0 degrees	3%
Plantar flexion	25 degrees	20 degrees	3%
Eversion	10 degrees	0 degrees	Combined 4%
Inversion	25 degrees	0 degrees	

25. Other grounds raised by Mr Skyrme were that the AMS did not apply Table 3.1 of the Guides[3] and, in view of the confusion in the reporting of his measurements, it could not be inferred that he had decided to ignore the approach taken by Dr Millons, who had been retained by the appellant, to use the Table as a "best – fit" assessment.

26. Mr Skyrme also submitted that the AMS had failed to assess impairment resulting from varus deformity of the right hind foot.

27. Mr Skyrme also submitted that the AMS had failed to give reasons regarding his assessment of scarring.

28. Whilst the respondent conceded the force of Mr Skyrme's submission regarding the erroneous recording of range of motion, it sought to resist the challenge on the basis that the AMS had failed to consider whether the application of Table 3.1 was appropriate.

29. The respondent also sought to resist the challenge that the AMS had failed to consider the varus deformity in his assessment.

30. The respondent also submitted that no error had been demonstrated with regard to the assessment by the AMS for scarring.

31. As to the request for a re-examination, the respondent neither consented nor opposed the application, but submitted that a re-examination for the purposes of assessing the varus deformity was not consented to, as it maintained that no error had been made in that regard.

32. However, the submission overlooks the effect of the principle in *Drosd* v Workers *Compensation Nominal Insurer*[4] which holds that where a demonstrable error has been found, the Panel is under an obligation to properly apply the Guides, and to correct any other errors that were discovered in the examination.

33. Dr Noll's report follows:

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[3] Guides page 16

[4] [2016] NSW SC 1053

“**REPORT OF THE EXAMINATION BY APPROVED MEDICAL SPECIALIST MEMBER OF THE APPEAL PANEL**

Matter No: M1-1728/19
Appellant: Robert Arch SKYRME
Respondent: Patrick Stevedores Holdings Pty Ltd

Examination Conducted By: Brian Noll
Date of Examination: 2 October 2019

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1. The workers medical history, where it differs from previous records

Mr Skyrme confirmed the history provided by the AMS in the Medical Assessment Certificate dated 7 June 2019 regarding the nature of the accident on 10 December 2014 and his subsequent treatment.

In addition to the information provided previously, Mr Skyrme indicated that the wound in relation to his right lower extremity repeatedly broke down after he left hospital and it was not until October 2015, some 10 months after the injury, that it finally healed. He said that the presence of the wound compromised his rehabilitation in that he could not exercise in a pool while the wound was open.

With regard to his current symptoms, he said that he is able to walk for only ‘a couple of blocks’ before experiencing pain in relation to both ankles and feet. He said that when he experiences pain it is initially about 2-3/10 (with 10 being the most severe possible pain) but becomes increasingly severe, up to 5/10, if he perseveres with standing or walking for any length of time. The pain could then take until the next day to settle. He indicated that the pain is felt predominantly over the anterior aspect of both ankles but emphasized that he also experiences pain in relation to both feet. He volunteered that he has no pain at rest.

He said that he is unable to walk on uneven ground.

He commented that he is very aware of the scarring and feels embarrassed by it. He said that he does need to apply moisturising creams on a daily basis.

He confirmed that he takes analgesic medication (Panadol Osteo) and anti-inflammatory medication (Mobic). He also takes Nexium for gastric reflux.

He confirmed that he has a previous history of an injury to his right knee which included a fracture of his patella and ligamentous injury. He said however that this resolved spontaneously, and he no longer has any symptoms in relation to his knee.

With regard to his work, he said that he continues to have limitations and has not been able to resume his pre-injury stevedore duties. His work now predominantly involves driving a ‘reach-stacker machine’ which is a type of crane.

He confirmed all the information provided regarding his activities of daily living and social activities.

2. Additional history since the original Medical Assessment Certificate was performed

He said that he has had no further investigations or treatment in relation to his lower extremities since seen for assessment previously on 7 June 2019.

3. Findings on clinical examination

Mr Skyrme weighs approximately 115kg and stands 178cm tall. He is right-handed. He walked with a halting gait, consistent with the marked stiffness noted in relation to both ankles.

He presented in a straight-forward and cooperative manner. The history given and clinical findings were consistent with the information in the documentation provided.

He had obvious difficulty attempting to walk on his toes and heels. He was able to squat down fully (by taking his weight on his forefeet when doing so). He could get up independently.

He had the following scarring in relation to his right lower extremity:
– A curved 12cm long scar over the lateral aspect of the ankle which included an elliptical region of skin grafting measuring 6cm in length and 2cm in width. The scar was pigmented, tethered to the underlying tissues, and associated with obvious stitch marks and a contour defect.
– A 10cm longitudinal scar extending from above the ankle region to the anterior part of the medial malleolus. The scar was mildly pigmented; there were obvious stitch marks and tethering to underlying tissues. The distal part of the scar included a raised hyper-keratotic prominence.

The following scarring was noted in relation to the left lower extremity:
– A 20cm longitudinal scar over the anterior aspect of the distal tibia and ankle region with areas of hypo and hyper-pigmentation and tethering to the underlying tissues. The surrounding skin was mottled with areas of increased pigmentation involving the distal third of the anterior aspect of the tibia down to the level of the ankle.

There was marked restriction of ankle movement bilaterally.

The right hindfoot was ankylosed with 15° of varus deformity. The varus deformity of the right heel was particularly obvious in the standing position.

There was minimal left hindfoot movement. The posture of the left hindfoot was normal in the standing position.

Active movements measured with a goniometer were as follows:

Ankle and foot Movements	Right	Left
Ankle plantar flexion	20°	20°
Ankle dorsiflexion	0°	0°
Hindfoot inversion	Ankylosed*	10°
Hindfoot eversion	Ankylosed*	0°

* 15° varus deformity.

Muscle strength in relation to the mobile lower extremity joints was normal on clinical testing. He reported increased skin sensitivity predominantly over the medial aspect of the left lower leg medial to the longitudinal scar.

There was no obvious lower extremity muscle wasting and circumferential measurement of the calves did not reveal any discrepancy between the two sides (43cm bilaterally).

4. Results of any additional investigations since the original Medical Assessment Certificate

No additional investigations were made available.

Review of the x-ray of the right ankle dated 4/09/18 revealed evidence of the internal fixatives including plate and screw fixation of the distal tibia. The x-rays revealed evidence of irregularity of the distal articular surface of the tibia and osteoarthritic changes with complete loss of ankle joint space.

Review of the x-ray of the left ankle dated 4/09/18 revealed plate and screw fixation of the distal tibia and osteoarthritic changes in relation to the ankle joint with the ankle joint space reduced to 1mm.

A CT scan of both feet and both ankles on 12/04/19 confirmed the findings noted on the x-rays dated 4/09/18.

The Panel adopts Dr Noll's report. Mr Skyrme has been markedly debilitated as a result of his injuries. The ranges of motion reported by Dr Noll demonstrate the following entitlements: "Impairment relating to the right lower extremity

Right ankle
AMA 5 Table 17 – 31 (page 544) indicates that complete loss of right ankle joint space noted on x-ray results in 30% lower extremity impairment.

AMA5 Table 17 – 11 (page 537) indicates that the restricted range of ankle plantar flexion (20°) results in 7% lower extremity impairment and the restricted range of ankle dorsiflexion (0°) results in 7% lower extremity impairment with the total being 14% lower extremity impairment.

According to the WorkCover Guides paragraph 3.5 (page 13) the evaluation giving the highest impairment rating is selected with the right ankle injury therefore resulting in **30% lower extremity impairment.**

Right hindfoot
According to the WorkCover Guides, Table 3.1 (page 16) ankylosis of the subtalar joint in optimal position results in 10% lower extremity impairment. According to Table 3.1(a) impairment for ankylosis in variation from the optimum position (15°) results in an additional 10% lower extremity impairment. The Guides indicate that the additional amounts are added with the total therefore being **20% lower extremity impairment** for the disorder of the hindfoot.

According to AMA5 (page 10) the impairment values for the ankle and hindfoot should be added with the total for the loss of ankle joint space (30%) and ankylosis of the subtalar joint with 15° variation from optimum position (20%), being **50% lower extremity impairment.**

According to AMA5 Table 17 – 3 (page 527) 50% of lower extremity impairment equates with **20% WPI.**

Impairment relating to the left lower extremity
Left ankle
AMA 5 Table 17 – 31 (page 544) indicates that 1mm of ankle joint space equates with 20% lower extremity impairment.

AMA5 Table 17 – 11 (page 537) indicates that the restricted range of ankle plantar flexion (20°) results in 7% lower extremity impairment and the restricted range of ankle dorsiflexion (0°) results in 7% lower extremity impairment with the total being 14% lower extremity impairment.

According to the WorkCover Guides paragraph 3.5 the evaluation giving the highest impairment rating is selected with the impairment for the right ankle injury therefore being **20% lower extremity impairment.**

Left hindfoot
According to AMA 5, Table 17-12 (page 537) limitation of inversion to 10° results in 2% lower extremity impairment and complete absence of inversion results in 2% lower extremity impairment with the total being **4% lower extremity impairment.**

According to AMA5 (page 10) the impairment values for the ankle and hindfoot should be added. The total value for the loss of ankle joint space (20%) and limitation of hindfoot movement (4%) is 24%.

According to AMA5 Table 17 – 3 (page 527) 24% of lower extremity impairment equates with **10% WPI.**

Scarring
The scarring which includes evidence of marked colour contrast due to areas of depigmentation and pigmentation; some trophic changes; obvious suture marks; contour defect; adherence to underlying tissues; and the need for regular treatment, falls into the category **4% WPI**. This includes the fact that there is a small area of skin grafting.

Combined value
The combined WPI for the right lower extremity (20%), left lower extremity (10%), and scarring (4%) is **31 % WPI.**"

34. For these reasons, the Appeal Panel has determined that the MAC issued on 7 June 2019 should be revoked, and a new MAC should be issued. The new 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 APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

H Mistry

Heena Mistry
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **1728/19**
Applicant: **Robert Arch Skyrme**
Respondent: **Patrick Stevedores Holdings Pty Limited**

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

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

Table - Whole Person Impairment (WPI)

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in WorkCover Guides**	**Chapter, page, paragraph, figure and table numbers in AMA5 Guides**	**% WPI**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Sub-total/s % WPI (after any deductions in column 6)**
Left Lower Extremity (ankle)	10/12/201 4 10% 0 10%	Para 3.5 Page 13 Para 3.16, 3.17 P 15, Para 3.37 Page 222	Table 17-11 Page 537 Table 17-12 Page 537 Table 17-31 Page 544 Table 17-3 Page 527	10	nil	10
Right Lower Extremity (ankle and subtalar joints)	10/12/201 4	Table 3.1 P 16 Table 3.1(a)	Table 17-31 Page 544 Table 17-11 Page 537 Table 17-3 Page 527 Para 1.4 Page 10	20	nil	20
Scarring	10/12/201 4	TEMSKI Table 14.1 Page 74	Table 8.2 Page 178	4	nil	4
Total % WPI (the Combined Table values of all sub-totals)					**31%**	

John Wynyard
Arbitrator

Dr Gregory McGroder
Approved Medical Specialist

Dr Brian Noll
Approved Medical Specialist

8 November 2019

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

H Mistry

Heena Mistry
Dispute Services Officer
As delegate of the Registrar