WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-2623/19**
Appellant:	**Macarthur Disability Services Ltd**
Respondent:	**Michelle Mott**
Date of Decision:	**6 January 2020**
Citation:	**[2020] NSWWCCMA 4**

Appeal Panel:	
Arbitrator:	**Jane Peacock**
Approved Medical Specialist:	**Dr Brian Noll**
Approved Medical Specialist:	**Dr Gregory McGroder**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 5 September 2019 Macarthur Disability Services Ltd (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Peter Giblin, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 8 August 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, and
    - 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 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).

PRELIMINARY REVIEW

6. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Workers compensation medical dispute assessment guidelines.

7. As a result of the Appeal Panel's preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination.

EVIDENCE

Documentary evidence

8. 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.

Medical Assessment Certificate

9. 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

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

FINDINGS AND REASONS

11. 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.

12. 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.

13. The matter was referred by the Registrar to the AMS as follows:

> "The following matters have been referred for assessment (s 319 of the 1998 Act):
>
> - **Date of injury:** 13 July 2014
> - **Body parts/systems referred:** Lumbar Spine, Left Upper Extremity, Urinary and Reproductive Systems
> - **Method of assessment:** Whole Person Impairment"

14. Dr Korbel was appointed as lead assessor. Dr Korbel assessed the urinary and reproductive systems and Dr Giblin assessed the lumbar spine and left upper extremity.

15. There is no appeal from Dr Korbel's assessment of the urinary and reproductive systems.

16. The appeal by the employer is from the assessment by Dr Giblin.

17. Dr Giblin assessed as follows:

WPI Body Part or System	**Date of Injury**	**Chapter, Page and Paragraph number in NSW workers compensation guidelines**	**Chapter, Page, Paragraph, Figure and Table numbers in AMA5 Guides**	**% WPI**	**%WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality**	**Sub-total/s % WPI** (after any deductions in column 7)
Lumbar spine	13/7/2014	Chapter 4 Page 26	Page 384 Table 15.3 DRE 4 category	22%	1/10th	19.8% rounded up to 20%
Left upper extremity	13/7/2014	Chapter 2 Page 13	Chapter 16	4%	0%	4%

18. There was no appeal from the assessment of the left upper extremity.

19. There was no appeal from the overall assessment of impairment of the lumbar spine at 22% whole person impairment (WPI). The appeal concerns the deduction made by the AMS under s 323 of one-tenth.

20. In summary, the appellant submitted that the AMS erred as follows:

    - The AMS erred with regard to the s 323 deduction noting that the worker had undergone two previous surgical procedures (in 2004 and 2010) at the L5/S1 level. The AMS made a one-tenth deduction whereas the appropriate deduction would have equated with DRE III with the deduction in the vicinity of 50%.

    - The AMS failed to consider why a one-tenth deduction would be at odds with the available evidence.

    - The AMS failed to recognise that in the circumstances there was prima facie evidence that the worker had a significant degree of pre-existing whole person impairment.

    - The AMS failed to indicate why an assessment greater than one-tenth would be too costly or difficult given the available history and clinical records.

21. In summary, the respondent worker submitted that the MAC should be confirmed as follows:

    - The 2004 surgical procedure was at the L4/5 level but acknowledges that the 2010 procedure was at the L5/S1 level.

    - After each of the previous injuries the worker eventually went back to her pre-injury social and work activities (other than that after the 2010 injury when she decreased her netball from three to two days per week and eventually stopped playing netball after about two years).

    - In reliance upon the authority of *Cole v Wenaline Pty Ltd [2010] NSWSC 78 (Cole v Wenaline)* the AMS appropriately concluded that a one-tenth deduction was appropriate.

22. The role of the AMS is to conduct an independent assessment on the day of examination. The AMS is required to take a history, conduct a physical examination, review the special investigations, make a diagnosis and have due regard to other evidence and other medical opinion that is before the AMS. The AMS must bring his clinical expertise to bear and exercise his clinical judgement when making an assessment of impairment and make such assessment in accordance with the criteria in the Guides. When considering the assessment of a deductible proportion under s 323 the AMS can only make a deduction if he considers in the exercise of his clinical judgment that the pre-existing condition, abnormality or injury has contributed to the level of permanent impairment assessed. Where the extent of the deduction would be too difficult or too costly to determine, the deduction will be one-tenth.

23. Here the AMS took a detailed history, which included detail of pre-existing injuries to the lumbar spine and prior surgeries as follows:

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

She was employed at Macarthur Disability Services as a Support Worker on a part-time basis 32 hours a week commencing in 2011. Her work environment was domestically orientated.

In the course of her duties on 13 July 2014 she sustained injuries to her left upper extremity and low back with referred symptoms into both her legs. This was associated with severe urinary incontinence. The injury occurred when she was attacked by an aggressive patient and she had to fight very forcibly to remove herself out of harm's way from the patient who was in a rage.

The patient was middle aged and weighed 120 kilograms. The attack continued for an hour and a half until her shift was finished.

The following morning, she was aware that she had increasing pain in her low back and left shoulder. She went to work on the next day on restricted duties and then went to see her GP at the end of the shift. A CT of the low back 25 July 2014 indicated a disc bulge at L3/4 with stenosis and disc bulge at L4/5. The disc at L5/S1 was seen to be rudimentary.

Further investigations included an MRI scan low back 6 August 2014.

She was commenced on physiotherapy. She complained of pins and needles in both hands. Episodic incontinence commenced in September 2014.

On 11 December 2014 she had an MRI scan of the left shoulder and her shoulder surgeon recommended an operation.

This was not proceeded with.

In 2015 she had a brief but unsuccessful attempt at a return to work on light duties.

She continued under the care of her treating neurosurgeon. There was an MRI scan of the pelvis 17 December 2015 reporting stenosis at L5/S1 contacting her left L5 nerve root.

She developed symptoms in both wrists and carpal tunnel symptoms were assigned to the investigation prognosis. A right wrist support was utilised. An update MRI scan of the lumbar spine January 2017 reported ongoing spondylitic changes.

On 18 September 2017 she had a low lumbar discectomy and fusion. It was an anterior approach. In the post-operative period, she reported no improvement in her back or left leg symptomatology and she noted she started to feel pain in the right leg. She commenced physiotherapy and hydrotherapy. The incontinence persisted.

An opinion from her treating neurosurgeon 13 June 2018 indicated that following her urodynamic test, the bladder issues were related to the compression of her lumbar nerve roots.

In mid-2018 she was admitted to Fairfield Hospital for bilateral carpal tunnel surgery, but this did not proceed based upon her history of severe reaction to medical medications.

She has not returned to paid employment to date.

- Present treatment:

At the moment she uses a walking machine at home, and utilises prescriptive medication such as Epilim as well as taking Panadol. She sees her GP every few weeks or so and her treating neurosurgeon, as required.

- Present symptoms:

She describes herself as having constant low back pain with burning in both her legs. These symptoms can refer as far as the left ankle and the top of the left foot. She has sharp needling pain in her arms, with intermittent pins and needles in both hands. Her left arm is different every day but she says her left shoulder feels stiff and painful but the right shoulder is okay.

She reports that her incontinence occurs at least four times a night and she has to use pads but no nappies. There is no symptoms reference her rectal sphincter.

She feels that there is a diffuse altered sensation on the tops and sides of her left leg but not the right side.

- Details of any previous or subsequent accidents, injuries or condition:

She has had no previous history of symptoms or injuries to her upper extremities.

In 2004 she sustained an injury when she was playing netball. This affected her low back and she was playing netball three times a week. She believes she had an L4/5 disc protrusion.

A discectomy operation on the left side, was carried out and she said she made a good recovery. At the time she was working in aged care and home care and she had about three months off work. She went back to her pre-injury recreational activities of playing netball three times a week and riding her 750cc Kawasaki motor bike and riding her jet ski most weekends in the summer. She was unrestricted in terms of domestic and occupational activities.

On 16 July 2010 she lifted a small TV and her back went out on her again. She had a diagnosis of a recurrent L4/5 disc protrusion and again she had surgery in the form of a discectomy.

Following the operation, she had several more months off work and then returned to her job.

Although she was still able to ride her jet ski and her motor bike, her return to netball activities was lessened. She was playing twice a week in a mixed team in an indoor comp.

She ran up against a rough team from Miller after about 2 years and she decided to back out altogether from then on as she was worried about her back.

- General health:

Her general health includes hypertension, asthma and medication allergies.

She is a non-smoker.

- Work history including previous work history if relevant:

Since leaving school, she has worked in childcare and aged and residential care as an AIN.
She was recently terminated from her job 13 July 2017.

- Social activities/ADL:

Leaving school in Year 10 she has a Certificate III in AIN.

At present she lives in a single storey, three bedroom and one bathroom house with her husband who works six days a week as a forklift mechanic. There are no dependent children.

She relies on him to do the heavy housework such as bed making, vacuuming, floors, mopping and shopping.

She is able to drive a car but not for long distances."

24. The AMS conducted a physical examination and his findings are not the subject of complaint on appeal.

25. The AMS reviewed the special investigations of the lumbar spine, including review of the films themselves where available and making comment thereupon as follows:

"CT scan lumbar spine (report only) 10 March 2010 - notes a broad disc bulge at L4/5. The S1 is partially lumbarised producing a transitional lumbosacral junction. Moderate spondylitic changes are referred to at L5/S1 with bilateral S1 nerve root compression. I cannot make a comment on that scan as it was not available for me to see.

MRI scan lumbar spine (report only) 3 May 2010 - notes post-surgical changes at L5/S1 with a left sided laminectomy. Moderate spondylitic changes are also found at L3/4 and L4/5.

CT scan lumbar spine - 25 July 2014 – notes multi-level spondylitic changes at L3/4 and L4/5. The disc at L5/S1 is referred to a rudimentary and most of the pathology is located at L4/5.
I have seen these x-rays. The rudimentary disc is, in fact S1/S2 and the bottom functional disc is L5/S1 which, would have been the surgical site in 2004 and 2010.

That is to say, there has been an error in terms of nomenclature in relation to the anatomical levels involved in the lumbo-sacral spine.

MRI scan lumbar spine - 6 August 2014 – notes sacralisation of L5 with most of the spondylitic changes being allocated to the L4/5 level.
(see above comment)
Ultrasound left hip (report only) 13 October 2014 – notes mild trochanteric bursa thickening.

MRI scan pelvis (report only) 17 January 2015 – notes no evidence of extra spinal left sciatic nerve compression or piriformis syndrome. Bilateral L5/S1 foraminal stenosis with contact of the left L5 nerve root is commented upon.

Multi-positional MRI scan - 3 June 2015 – is only one page, defines no specific abnormality in the upper and mid-levels but does not comment upon L5/S1 which is probably missing.
I have seen these films, and the spondylitic changes are primarily and moderately severe located at L5/S1. There is evidence of diminished epidural fat around the right L5 nerve root.

Bone scan (report only) 10 June 2015 – which shows no evidence of infection of discitis in the lumbar spine area.

Gallium scan (report only) 12 June 2015 – does not show evidence of active discitis or osteomyelitis.

Bone mineral densitometry (report only) 19 August 2015 – reports normal bone density.

CT guided discogram L4/5 and L5S1 - 21 August 2015 – notes it was negative at L4/5 and positive at L5/S1.
(I have seen these films and the correct level has been anatomically identified in terms of numbers)

Multipositional MRI scan lumbar spine - 18 January 2017 – does not report any significant abnormality until the L5/S1 level which records a broad disc osteophyte with annual tear and degeneration and some early foraminal stenosis and abutting S1 nerve roots.

CT scan abdomen and lumbar spine - 19 September 2017 – are post-surgical in nature showing the anterior interbody fusion at L5/S1.

Bone scan (report only) 19 March 2018 – refers to post-surgical changes at the L5/S1 level.

CT scan lumbar spine - 4 June 2018 – notes the post-surgical changes at L5/S1.

I have read a copy of the neurology report of Dr M Dowla 28 June 2018 in which he finds a normal gait, no weakness in the lower extremities, knee and ankle jerks being present but sluggish and subtle reduced impairment of cutaneous sensation of both outer thighs.

The nerve conduction study was performed, but the conclusion is not available.

I have noted a copy of nerve conduction studies from Dr Neil Griffith dated 10 October 2016.

The conclusion is not available."

26. The worker suffered injury on 13 July 2014 and thereafter came to spinal fusion surgery as a result. The fusion surgery entitled the worker to an assessment in DRE IV or 20% WPI.

27. The AMS has clearly explained his assessment, including his reasons for making a deduction under s 323 and his reasons for the extent of the deduction made at one-tenth as follows:

"In making that assessment I have taken account of the following matters:

The principal matter of history goes back to the incorrect naming of the lumbar disc levels.

It is apparent from the radiological investigations and history, that the L5/S1 disc has always been the source of pathology requiring surgical intervention. This is medically supported by the finding of an absent left ankle jerk.

There is a clear history of an excellent result from the first laminectomy and a very good result from the second laminectomy, but not quite as good as the first one based upon self-imposed intuitive physical restrictions at the upper end of musculo-skeletal activity, namely the netball.

a) An explanation of my calculations (if applicable)

In terms of the assessment of the left upper extremity, reference is made to Chapter 16, page 433 of the Guides.

As the current Workcover Guidelines direct the assessor to utilise the methodology that produces the greatest WPI assessment, I have made the assessment on an active range of motion. I did consider other disorders such as impairment due to peripheral nerve disorders, but on this occasion as a result of the physical examination, the active range of motion methodology was assessed. A comparison with the right upper extremity was made and I found no deduction to be applicable.

In assessing the lumbar spine, chapter 15, Table 15.3 on page 384 of the Guides was utilised.

Given that she'd had surgery on the lumbar spine in the form of a fusion, this satisfied the requirements as noted under a DRE 4 category on Table 15.3. This attracted an allocation of 20%WPI. In assessing the Activities of Daily Living, reference is made to paragraph 4.34 and 4.35 on page 28 of the current Guidelines.

I am satisfied, given her history and physical examination that she has difficulties with home care and therefore I have assessed her as having a further 2%WPI. I did consider 3% reference her urinary incontinence but that will be considered by the Lead Assessor and I chose to avoid double dipping.

Because one of the IMEs had concluded that there was a further WPI under Table 4.2, page 29 of the Guides, I took steps to carefully assess the complaint of symptoms in her left lower extremity and to match this with signs.

Table 4.2 on page 29 indicates that to attract a further 3%, there must be residual symptoms and radiculopathy.

The radiculopathy on page 27 must include positive nerve root tension sign with muscle wasting and imaging studies consistent with the clinical signs as well as loss of asymmetry of reflexes and muscle weakness anatomically localised to an appropriate spinal nerve root distribution with impaired sensation in an appropriate spinal nerve root distribution.

These requirements, are outlined in a numerical and generic fashion on page 27.

On this occasion, today's physical examination revealed altered sensation in a distribution that was not compatible with an appropriate spinal nerve root distribution or a peripheral nerve.

Although there was loss of the left ankle jerk which was asymmetrical compared to the present right ankle jerk, there was no muscle weakness anatomically located to an appropriate spinal nerve root distribution. In addition, I could not find objective evidence of muscle wasting and I was not satisfied that there was positive nerve root tension signs.

The imaging studies, were consistent with spondylosis, but there was no clear radiological evidence of ongoing peripheral nerve root compression or oedema. On that basis, I could not be satisfied that there was an impairment assessment as per the requirements on Table 4.2 on page 29.
I then turned my attention to the consideration of Section 323 deduction.

There is a degree of tension between the medical and legal interpretations.

From my perspective, there is an application of science, required by the medical practitioner with a bridge leading to the legalised humanist and collective directives of a society.

I am cognisant of the Cole v Wenaline Pty Ltd precedent.
-
I note that there is a requirement to record the extent and time of pre-existing impairment and whether or not this pre-existing impairment contributes to the impairment and proportion of the impairment was due to the pre-existing condition.

On those bases, I note that the L5/S1 disc was surgically involved in 2004 and 2010. Following the 2010 operation, there was some degree of intuitive self-imposed physical restriction in relation to sporting activities.

Both the CT scan and MRI scan of 2010 show at least moderate spondylitic changes at the L5/S1 level. From an anatomical structural view, the engineering of the lumbar spine was permanently compromised.

Therefore, it would be my view that there has been some degree of pre-existing impairment at the L5/S1 disc affecting the lumbar spine, prior to the subject injury of 13 July 2014. This pre-existing condition did contribute to the impairment to a minor extent, at least.

On those bases, I have made a deduction of 1/10th under Section 323 on the basis that it is too difficult or costly to make a greater or more direct determination."

28. The AMS made comment on the other evidence before him, including explaining why he has made a deduction under s 323 when no one of the other independent medical experts do so, as follows:

"I have read a signed and dated copy of the Statement of Ms Mott dated 17 May 2019.

I have read a copy of the report of Dr Paul Carney 26 October 2015. His physical examination findings refer to a diminished left ankle jerk. There was no reference to asymmetry in relation to motor or muscle testing in the lower extremities.

I have read a copy of the report of Dr Graeme Mendelsohn 6 February 2017 in which the history of the present illness is briefly referred to. Physical examination records symmetrical reflexes in the lower extremities, but both ankle jerks are absent. There is 1cm reduction in the girth of the left thigh with calves being symmetrical. There was apparent decreased sensation in the left thigh, calf and foot and ankle. He notes a BMI of 33.

I prefer my own findings and conclusions.

I have read a copy of the report of Dr Michael Ryan dated 5 February 2019. His physical examination recorded normal sensation in the lower extremities with diminished straight leg raising more on the left than the right. Power of the muscle groups of the lower extremities is seen to be Grade 5.

The examination of the left upper extremity refers to the shoulder which is quantified but not qualified, and not cross referenced.

In his impairment assessment he allocates 22% Whole Person Impairment for a DRE 4 category injury to the lumbar spine with 5% Whole Person Impairment for the left shoulder.

Dr Ryan makes no reference to Section 323 considerations.

I have general agreement with his physical findings.

I have read a copy of the report of Dr John Bosanquet 10 May 2019 in which the history of the injury is outlined. The lumbar spine examination records no sensory deficit in the lower extremities with knee and ankle jerks being present.

He notes the right calf is 1cm larger than the left side. Two surgical scars are noted, one anteriorly and one posteriorly. The left shoulder is examined from the point of view of range of motion which is quantified, not qualified, and not crossed referenced. (I do not agree with his physical finding insofar as I find the circumference of each calf is the same, and the left ankle jerk is definitely absent to repeated testing)

X-ray investigations include MRI scans of the lumbar spine and left shoulder with a bone scan of 2015 and a CT scan of the lumbar spine. There are multiple investigations of the lumbar spine. Nerve conduction studies dated 28 June 2018 are commented upon briefly.

Dr Bosanquet assesses a DRE 4 category injury equating to a total of 22% Whole Person Impairment with a further 5% Whole Person Impairment in relation to the left upper extremity which is referenced as the shoulder.

Dr Bosanquet makes a comment in relation to deductions, but he does not do this himself on the basis that previous surgeries were not related to the L5/S1 disc.

I have given my reasons as to the issue of Section 323 and the matters pertaining to anatomical nomenclature.

By inference, this would point to a very good but not a total or complete recovery and this would be a normal expectation following surgery at that level in a lumbar spine. This clinical and radiological picture matches the expected experience of the perennial and insoluble problem of a manual worker with a structurally compromised lumbar spine."

29. The AMS addresses the question of the deduction for the pre-existing condition, abnormality or injury as follows:

"(a) In my opinion the worker suffers from the following relevant previous injuries, pre-existing conditions or abnormalities:

(i) Pre-existing lumbar spondylosis

(b) The previous injury, pre-existing condition or abnormality directly contributes to the following matters that were taken into account when assessing the whole person impairment that results from the injury, being the matters taken into account in 10a, and in the following ways:

(ii) Structurally compromised lumbar spine with some diminished physical stamina.

(c) The extent of the deduction is difficult or costly to determine so in applying the provisions of s.323(2) I assess the deductible proportion as one tenth."

30. The AMS has thoroughly reviewed the special investigations including viewing himself the films where available. The AMS has indicated that review of the imaging studies indicates that the previous surgery in 2004 and 2010 and the spinal fusion in September 2017 were all at the L5/S1 level. The AMS has indicated that the multi-positional MRI scan dated 3/06/15 revealed that *'… all spondylitic changes are primarily and moderately severe located at L5/S1'.*

31. The AMS has provided a detailed explanation regarding the pre-existing condition of the lumbar spine both with regard to the previous surgeries and the available information regarding symptoms which predated the injury the subject of the referral on 13 July 2014.

32. The worker suffered injury on 13 July 2014 and subsequently came to fusion surgery. This entitled the worker to an assessment at DRE IV or 20% WPI (22% WPI after allowance for ADLs). A deduction under s 323 could only be made by the AMS if he was satisfied that the pre-existing condition of the lumbar spine had contributed to the level of permanent impairment assessed. He clearly explained why he was so satisfied as well as explaining why the deduction was made at the extent of one-tenth.

33. The appellant's comments regarding possible alternative pre-existing DRE levels of impairment is not the correct approach to take when determining the s 323 deduction. A s 323 deduction is based on the AMS' assessment of the contribution of the pre-existing condition to the overall level of permanent impairment assessed. The overall level of permanent impairment assessed in this case in based upon the fusion surgery performed after the subject injury. It is not a correct approach to the assessment of the deduction for pre-existing condition to assess WPI on the basis of DRE levels of impairment due to the prior surgeries in 2004 and 2010 and then deduct those DRE assessments from the overall level of impairment that results from the fusion surgery as a result of injury on 13 July 2014.

34. The AMS has specifically referred to the authority of *Cole v Wenaline*. The fact that there has been previous surgery at the same level does not necessarily mean that this has resulted in a pre-existing level of impairment greater than one-tenth. Evidence of an ongoing complaint resulting in limitation of activities would be necessary in order to make a greater than one-tenth deduction. The level of deduction of one-half suggested by the appellant would be inappropriate taking into account the history that the worker continued with her normal work and also continued to play netball following the 2010 operation.

35. In this case, the panel can discern no error in the assessment of the AMS in making a one-tenth deduction under s 323 to take account of the contribution of the pre-existing condition of the lumbar spine to the level of permanent impairment assessed as a result of the injury referred to him. He has clearly explained his approach and the Panel can discern no error.

36. For these reasons, the Appeal Panel has determined that the MAC issued on 8 August 2019 should be 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*.

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION