WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-645/19**
Appellant:	**Jason Peter Waters**
Respondent:	**Alcheringa Park Thoroughbred Pty Ltd**
Date of Decision:	**13 December 2019**
Citation:	**[2019] NSWWCCMA 184**

Appeal Panel:	
Arbitrator:	**John Wynyard**
Approved Medical Specialist:	**Dr Mark Burns**
Approved Medical Specialist:	**Dr Robin Fitzsimons**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 31 May 2019, Jason Peter Waters (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Ross Mellick, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 3 May 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 Guides) 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. On 19 March 2019 a delegate of the Registrar referred this matter to the AMS for an assessment of WPI caused to:

   - the lumbar spine,
   - cognitive impairment (nervous system), and
   - scarring by injuries on 5 September 1996 and 7 September 1998.

7. The face of the referral referred to six previous awards or settlements regarding either or both dates of injury.

8. Mr Waters was the stud manager and the horse trainer of the respondent company.

9. On 5 September 1996 Mr Waters was riding a horse when it stumbled and fell, rolling on top of him. He was aware of back pain but there were no symptoms in the lower limbs. Mr Waters wore a back brace for six to eight weeks and was able to return to full time work on a graduated program beginning on light duties.

10. On 7 September 1998, he suffered a further injury about which he has no memory and to which there were no witnesses. He thought he sustained a further injury possibly after being kicked by a horse. He was taken to Maitland Hospital and admitted to hospital for a period of time. He told Dr Michael J Davies on 10 April 2014[1] that he believed that he was unconscious but Dr Davies, the AMS who was examining whether proposed spinal surgery was reasonably necessary, did not have available records regarding loss of consciousness.

11. Further details of the injury of 5 September 1996 were recorded by Dr Tim Anderson, who was the AMS to whom the matter was referred for an assessment pursuant to the Table of Disabilities of permanent impairment of the back and loss of efficient use of the left leg.

12. The history given was that when Mr Waters was riding a horse it "knuckled under" (tripped and went down on its forelegs) which resulted in Mr Waters being catapulted to the ground in front of the horse, which then rolled on him, got up and ran away.

13. Regarding the injury on 7 September 1998, the history taken by Dr Anderson was consistent, in that Mr Waters did not know what happened. He told Dr Anderson, however, that he believed that the young horse reared and kicked him on the head, as it was later identified that there was a large lump on the back of his head to the right side, with a laceration which needed suturing[2].

14. Those histories were confirmed by Mr Waters in his statement of 6 February 2017, taken in relation to his back and leg problems.

15. Mr Waters said that he had amnesia for about 12 days following the head injury and had "suffered some loss of brain function since this time"[3].

16. Mr Waters has suffered from back pain following the first injury but after the second it became worse and he developed symptoms in the left lower extremity for the first time. He also reported impairment of memory from that time.

17. He came to a discectomy at L5/S1 with Dr Abe Isaacs, Orthopaedic Surgeon, some time in late July 2014. That had some success in easing the leg pain but Mr Waters developed a post-surgical infection in his back which necessitated further surgery. Regrettably the symptoms returned and increased in his back and left leg.

18. The AMS recorded complaints of impairment of memory by Mr Waters (which has caused Mr Waters to keep a diary) and considerable mood disorder requiring psychiatric care for mood depression. It was noted that Mr Waters was comfortable in company and there was no indication of withdrawal from the community. He complained of headache in the right frontotemporal region with some increased sensibility to noise and light on an unpredictable basis about once a week.

[1] Appeal papers page 180
[2] Appeal papers page 191
[3] Appeal papers page 199

19. The AMS certified nil WPI arising from the injury of 5 September 1996 and found with regard to the injury of 7 September 1998 that Mr Waters suffered 16% WPI in relation to the lumbar spine and nil WPI for cognitive impairment (nervous system and scarring).

PRELIMINARY REVIEW

20. 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.

21. Mr Waters sought to be re-examined by a Panel AMS. As a result of that preliminary review, the Appeal Panel determined that a demonstrable error has been made, and accordingly requested that the worker undergo a further examination for the reasons given below. The re-examination took place in Newcastle on 17 October 2019 with Dr Mark Burns of the Panel.

EVIDENCE

Documentary evidence

22. 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

23. Dr Mark Burns of the Appeal Panel conducted an examination of the worker on 19 September 2019 and reported to the Appeal Panel.

Medical Assessment Certificate

24. 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

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

FINDINGS AND REASONS

26. 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.

27. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 *(Vegan)* 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.

28. The ground of appeal concerned the assessment of 0% WPI for cognitive impairment (nervous system). Mr Waters has submitted that the AMS has fallen into error because he has failed to identify those criteria that he was applying, thus depriving the reader of an ability to discern whether he had correctly applied the relevant criteria or not.

29. In his Summary, the AMS said:[4]

> **"7. SUMMARY**
>
> **summary of injuries and diagnoses:**
>
> The first injury did not cause any assessable impairment. The second injury results in lumbar spine symptoms and evidence of radiculopathy which persisted after surgery. There is no adequate evidence of a brain injury justifying a WPI assessment. Surgical scarring is very difficult to identify and accordingly it does not reasonably justify an assessment."

30. In giving his reasons for assessment, the AMS said[5]:

> **"10. REASONS FOR ASSESSMENT**
>
> **a. My opinion and assessment of whole person impairment**
>
> There is assessable whole person impairment.
>
> In making that assessment I have taken account of the following matters:-
>
> > My findings with regard to the history, the findings on examination and the documentary evidence I have received."

31. The AMS then considered the opinions of other specialists that had been given. Dr Warwick Stening, Neurosurgeon, had been retained as medico-legal referee for Mr Waters. Dr Stening issued reports dated 16 May 2018 and 28 December 2018. The AMS did not refer to the second of those reports.

32. In referring to the report of 16 May 2018 the AMS noted that Dr Stening had seen the reports of three neuropsychological assessments dated 11 November 2018, 2 December 2018 and 7 December 2018. The AMS noted that Dr Stening commented that those reports were made two or three months following the second injury, and that improvement could be expected over time.

33. The AMS also reproduced Dr Stening's comment that the psychological assessments suggested that the magnitude of cognitive impairment was not in keeping with the evidence of the severity of the head injury. The AMS then noted that Dr Stening did not consider that an assessment of WPI in respect of the head injury was justified and said:

> "….At the time of [Dr Stening's] assessment, he assessed the whole person impairment to be 0%"

34. However, the AMS did not then refer to the second report of Dr Stening dated 28 December 2018, in which he assessed at 25% WPI for the head injury on receipt of a neuropsychological assessment by a clinical psychologist, Ms Jenny Wong of 3 September 2018. Dr Stening said[6]:

> "As a neurosurgeon pursuant to the Code of Conduct for Expert Witnesses, I do not have the expertise to analyse this assessment. I therefore, must accept her assessment of a WPI 25%."

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[4] Appeal papers page 20
[5] Appeal papers page 21 [10]
[6] Appeal papers page 55

35. The AMS also referred to the opinion dated 15 November 2017 of Dr Dudley O'Sullivan, Neurologist, who had been retained as a medico-legal referee for the respondent. The AMS reported that Dr O'Sullivan had available to him reports from Dr Dennis Crimmins and Dr Paul Darveniza, both Neurologists. The AMS noted that Dr Darveniza, in a report of February 2012 made an assessment of 0% WPI, using the "CDR scale".

36. Dr O'Sullivan, the AMS noted, also noted a 0% in relation to cognitive impairment (nervous system).

37. The AMS then said[7]:

> "It is noted that they, too, did not identify adequate evidence to make a whole person impairment assessment for cognitive impairment (nervous system) because of the injury on 7 September 1998. Accordingly, my opinion is in accord with the body of neurological and neurosurgical opinion in that regard."

SUBMISSIONS

38. Mr Waters submitted firstly that the relevant guidelines in Chapter 5 of the Guides and Chapter 13 of AMA 5 had not been mentioned, let alone considered, by the AMS.

39. As we understood his submission, Mr Waters submitted that the assessor had not taken care to be "as specific as possible" at all, as required by Chapter 5.4 of the Guides, and his reasons were not evident on the face of the certificate.

40. Mr Waters further submitted that Ms Jenny Wong, Psychologist, was the only person who had undertaken a neuropsychological assessment in recent years, and that Dr Stening accepted that assessment in his report of 28 December 2018.

41. Neither Ms Wong's report nor Dr Stening's adoption of it were mentioned by the AMS, and it was submitted that his failure to refer to those reports too amounted to a demonstrable error.

42. The AMS, in considering the reported impairment of memory and the need for Mr Waters to keep a diary said[8]:

> "I consider the impairment of memory, to which I refer above, and the need for a diary is adequately explicable on the basis of the 'considerable mood disorder' and the need for psychiatric care for depression."

43. The reference to the "considerable mood disorder" was a reference to the history the AMS had taken from Mr Waters himself. Mr Waters submitted that the explanation by the AMS "does not sit well" when the AMS had before him opinions of the treating psychiatrist Dr Timothy McDonald who had been assessing Mr Waters over 18 years. At the very least, it was submitted, some consideration of that evidence should have been given.

44. Reference was made to *Marina Pitsonis v Registrar Workers Compensation Commission*[9] in furtherance of a concession that a difference of medical opinion was not an appellable point. However, Mr Waters submitted that if an opinion is rejected by an AMS, then adequate reasons were required to be given. The same considerations applied to the report of Ms Wong, it was submitted.

45. Reference was made to the relevant paragraphs at Chapter 5 of the Guides and to Chapter 13 of AMA 5.

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[7] Appeal papers page 22
[8] Appeal papers page 22
[9] [2008] NSWCA 88 (*Marina Pitsonis*)

46. Mr Waters noted that the assessment was for the purposes of s 39 of the *Workers Compensation Act 1987* (1987 Act), which we note is concerned with the awarding of further weekly compensation. It was noted that lump sum compensation for brain impairment had been assessed pursuant to the Table of Disabilities (although we were unable to locate that particular award).

47. Mr Waters submitted "particularly for this reason" that due consideration had to be given to the existing clinical and other material. We assume that Mr Waters intended by the word "reason" to refer to the purpose of the assessment being pursuant to s 39 of the 1987 Act and the subordinate legislation contained in Schedule 8 of the Workers Compensation Regulation 2016.

48. Mr Waters then referred to an assessment by a neuropsychologist, Ms Tanya Kerr who had supervised the assessment of Mr Waters from the Hunter Rehab Brain Injury Service, and who had provided several reports that were attached to the application.

49. It was submitted that those reports recorded an array of functional disabilities and that the clinical material also included occupational therapy and speech therapy records. Mr Waters asserted that there appeared to be agreement amongst the treating practitioners that there was an element of psychological disorder and/or psychiatric presentation which led to his being referred to Dr McDonald.

50. Mr Waters submitted:

> "While a careful examination is required to form an appreciation of a relatively complex symptom set, the following excerpts demonstrate examples of Dr McDonald's identification of neurological injury as being responsible, at least in part for the patient's disability ……"

51. Reference was then made to reports from Dr McDonald of 14 August 2000, 8 April 2003, 9 July 2008 and 30 September 2009 which Mr Waters submitted pointed to neurological involvement.

52. Mr Waters also criticised aspects of the AMS's approach to the opinions of other specialists, repeating that he had not referred to Dr Stening's second report, nor to Ms Wong's assessment.

53. The respondent did not attempt to engage with the substance of the submissions made by Mr Waters, contenting itself to submit, without explanation, that the matter should be determined on the papers. It simply said that no basis for the grounds of appeal raised had been shown either in relation to the failure to apply correct criteria or as to demonstrable error.

54. The reluctance by the respondent to engage with any of the specific points raised by Mr Waters speaks for itself.

DECISION

55. An AMS is not required to engage with all material sent to him. However, he is required to give adequate reasons, as we have indicated above in our reference to *Vegan*.

56. The failure by the AMS to refer to the Guidelines which were relevant to his assessment we find to be a failure to give adequate reasons. We concur that, without an explanation by reference to those Guidelines, the parties (and indeed the Panel) were unable to discern the basis of the assessment. We are not able to rule whether incorrect criteria has been applied, as no criteria has been mentioned by the AMS. We are satisfied however that the failure to refer to the relevant criteria is a failure to give adequate reasons and a demonstrable error.

57. Accordingly, a re-examination was necessary to properly assess Mr Waters' WPI regarding cognitive impairment (nervous system). Dr Burns report follows:

"REPORT OF THE EXAMINATION BY APPROVED MEDICAL SPECIALIST MEMBER OF THE APPEAL PANEL

Matter No:	**M1-645/19**
Appellant:	**Jason Peter Waters**
Respondent:	**Alcheringa Park Thoroughbred Pty Ltd**

Examination Conducted By: **Dr Mark Burns**
Date of Examination: **17 October 2019**

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

History

- Mr Waters confirmed the history of the two injuries as recorded by Dr Mellick, AMS.

- He confirmed that he did not sustain a head injury in the initial accident on 5 September 1996. He also confirmed that he has no memory of the second accident on 7 September 1998. When asked about his last memory prior to this accident he was unable to do so due he stated to the length of time since the accident. With respect to his first memory after the accident he stated it was about 1 week before his discharge from hospital (which from the records was 17 September 1998). This would make his post-traumatic amnesia only 3 days! He believes that about 4 days before discharge he was mobilized by the physiotherapist.

- He was clinically diagnosed in hospital as having a traumatic head injury.

    - He has a recorded 'possible' loss of consciousness. From the new 'legible' copy of the records of Maitland Hospital, his Glasgow Coma Scale Score (GCS) from the Emergency Department Clinical Examination was 14/15. On 4 further occasions, three on 7 September and 1 on 8 September on the Neurological examination chart he was noted to be confused. This would give a GCS of 14/15 on each occasion.

    - His medically verified period of Post Traumatic amnesia is listed in the documents as 8 days. This is inconsistent with the hospital records which on 13 September 1998 state "Pre-traumatic amnesia however displays no post-traumatic amnesia (Rehab OT)." This comment is more consistent with Mr Waters stated first memory after the accident.

    - There was no intracranial pathology noted on the CT scan of the brain on 7 September 1998. Right temporo-parietal extracranial soft tissue swelling was noted.

- He was referred to the Brain Injury Rehabilitation Unit in Newcastle on 17 September 1998 and attended as an outpatient until June 1999, under the care of Dr Booth, Rehabilitation Physician.

- Neuropsychological testing was performed at the Brain Injury Unit in November & December 1998. The following conclusions were obtained;

  ‘Mr Waters is a man of average intellectual ability who is performing at a level below that which would be expected across both verbal and non-verbal problem solving with marked slowing of information processing, concreteness in reasoning and poor initiation and regulation of problem-solving strategies.
  Attentional regulation is poor as is immediate memory span and working memory. Mr Waters demonstrates significantly impaired recent memory, which is most apparent for visual material. Executive impairments are demonstrated by inflexibility of thought and difficulty adapting behaviour in response to feedback.
  As he was assessed only 2·3 months since sustaining a traumatic brain injury, it is likely that areas of cognitive impairment identified on assessment will resolve at least in part over time.

  The magnitude of cognitive impairments identified on assessment is not in keeping with the nature of available medical information detailing the severity of Mr Waters' brain Injury. The potential Interplay of organic and emotional factors therefore needs to be taken into account when interpreting the assessment data. Indeed, Mr Waters presented as being highly anxious on initial clinical assessment with further evidence of depressive symptomatology. Assessment was interrupted at a number of stages to address presenting adjustment issues.
  Referral was made for psychiatric assessment and ongoing psychiatric counselling support which is currently in progress’.

  ‘Neuropsychological re-assessment is recommended in 3 - 12 months to assist in more clearly delineating the influence of psychological versus organic factors in Mr Waters' presentation.’

- At the time of Case Closure from the Brain Injury Unit he was reported as having ongoing cognitive and behavioral issues. It was recommended that he attend services closer to home.

<u>Current Symptoms</u>

- I discussed with Mr Waters symptoms potentially referable to his head injury;

  - **Memory:** He states that this is a lot better than immediately after his head injury. He continues to use a diary for appointments and non-regular activities. He tends to check the diary daily so as not to miss activities. **(0.5)**

  - **Orientation:** He is well orientated in time and person but has difficulty when going to new locations. He was able to confirm the date and time of my appointment and remembered my name as well as the Prime Minister’s name. When he goes to new places his father normally drives him. Around his local area he drives. **(0.5)**

  - **Judgement and Problem Solving:** On a day to day basis he looks after this own money and payments. He only consults his mother when making “big” decisions which occur very rarely. This occurs very infrequently and is mostly to confirm his decision. **(0)**

  - **Community Affairs:** He continues to be involved in racing, attending meetings at both Cessnock and Newcastle. Normally his son takes him.

He socializes on these occasions with friends from his time in the industry. He does report having difficulty with new acquaintances.

He stated that he follows the form guide on a regular basis to keep his hand in. He also goes to the movies on a monthly basis. **(0)**

- **Home and Hobbies:** He has lived with his parents in their house since his divorce in 2000. It is a single-story house on a normal block. He looks after his own room and helps with lighter tasks. His capacity to do household activities is limited by his back condition, not his cognitive impairment.

He has 6 grandchildren, 4 of whom live nearby (5-6km drive). He sees them 4 – 5 times per week and has a good relationship with them. **(0)**

- **Personal Care:** He agreed that he was fully capable of self-care and required no prompting. **(0)**

(Bracketed figures at the end of each of the above six-subsections refer to the consequently assessed numerical designation for purpose of CDR calculation, as provided in Table 13-5, AMA5. It should be noted that a designation of 0.5 when applied to the above subsets may also be designated as "questionable").

- When questioned about his mood he reported bouts of depression mostly due to his restrictions from his back injury. He also reported regular migraine headaches. When asked about irritability he reported that over time since the accident that his irritability has improved.

<u>Current Treatment</u>

- He attends Dr Singh, his long-term GP once a month for prescriptions and certificates. He is currently prescribed the following;
    - Efexor
    - Seroquel
    - Avanza
    - Targin
    - Panadeine Forte
    - Topamax and
    - Imigran.

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

Mr Waters reported no change in his condition or treatment since his assessment by Dr Mellick.

3. Findings on clinical examination

Mr Waters was 178cm tall and weighed 142kgs.
Cranial nerve examination revealed no abnormality
Neurological examination of both upper limbs revealed no abnormality.

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

- No further investigations have been performed.

Signed: Dr Mark Burns

Date: 17 October 2019"

58. The panel adopts Dr Burns' report.

59. The relevant guidelines are to be found in Chapter 5 of the Guides, which is entitled "Nervous system." It incorporates the provisions of Chapter 13 of AMA 5, subject to modifications set out in Chapter 5.

60. Chapter 5.4 provides:

"The approach to assessment of permanent neurological impairment

5.4 AMA5 Chapter 13 disallows combination of cerebral impairments. However, for the purpose of the Guidelines, cerebral impairments should be evaluated and combined as follows:
- •• consciousness and awareness
- •• mental status, cognition and highest integrative function
- •• aphasia and communication disorders
- •• emotional and behavioural impairments.

The assessor should take care to be as specific as possible and not to double -rate the same impairment, particularly in the mental status and behavioural categories.
These impairments are to be combined using the Combined Values Chart (AMA5, pp 604–06). These impairments should then be combined with other neurological impairments indicated in AMA5 Table 13-1 (p 308)."

61. Chapter 5.9 of the Guides[10] provides as follows:

"Specific interpretation of AMA5

5.9 In assessing disturbances of mental status and integrative functioning; and emotional or behavioural disturbances; disturbances in the level of consciousness and awareness; disturbances of sleep and arousal function; and disorders of communication (AMA5 sections 13.3a, 13.3c, 13.3d, 13.3e and 13.3f; pp 309–311 and 317–327), the assessor should make ratings based on clinical assessment and the results of neuropsychometric testing, where available.
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.

[10] Guides page 32

Neuropsychological testing should be conducted by a registered clinical neuropsychologist who is a member, or is eligible for membership, of the Australian Psychological Society's College of Clinical Neuropsychology. Neuropsychological test data is to be considered in the context of the overall clinical history, examination and radiological findings, and not in isolation."

62. Chapter 13.2 of AMA 5[11] provides a five-step process for evaluating these areas of function.

63. Chapter 13.2 of AMA 5 provides that Table 13 - 6 should be used to evaluate cerebral impairments involving mental status, cognition and highest integrative function. Chapter 13.3d defines "mental status, cognition and highest integrative function," and provides for the Clinical Dementia Rating (CDR) at Table 13 - 5.[12]

64. It is this scale that Dr Burns applied under "Current Symptoms" in his report. The figures in parenthesis at the end of each subject are provided for in the Table, which is divided into five classes as follows:

    1. 0
    2. 0.5
    3. 1
    4. 2
    5. 3

65. Table 13 - 6[13] is entitled "Criteria for Rating Impairment Related to Mental Status," and provides four classes of WPI evaluation, namely:

    1. 1% to 14%
    2. 15% to 29%
    3. 30% to 49%
    4. 50% to 70%

66. The criteria for class 1 are described as "paroxysmal disorder with preimpairment exists, but is able to perform activities of daily living."

67. Class 2 criteria are described as "impairment requires direction of some activities of daily living."

68. Class 3 criteria are described as "impairment requires assistance and supervision for most activities of daily living."

69. The criteria for class 4 are "unable to care for self and be safe in any situation without supervision."

70. It can be seen that the evaluation of this type of injury is complex and requires consultation with both the Guides and AMA 5. The Panel also initially had considerable difficulty in deciphering the notes from Maitland Hospital, as they appeared to have been copied and recopied several times. On 19 August 2019, we issued a direction seeking the production of legible notes, which were duly provided. They established that Mr Waters did have an initial abnormal CCS score of 14/15 and thus fulfilled the section of Chapter 5.9 of the Guidelines for diagnosis (and assessment) of a traumatic brain injury. They also established that he did not have a "significant medically verified duration of post-traumatic amnesia".

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[11] AMA 5 page 308
[12] AMA 5 page 320
[13] AMA 5 page 320

71. With reference to the criteria in Chapter 5.4 of the Guides, we are satisfied firstly that there was no evidence that Mr Waters' injury has permanently affected his level of consciousness or awareness.

72. Secondly, with regard to emotional and behavioural impairments, the evidence from Mr Waters' treating psychiatrist demonstrates that these were apparent in the early stages. In his last report of 24 February 2016, Dr McDonald, found that Mr Waters suffered from "personality change and a variety of subtle neurological deficits caused by closed head injury at work in 1998".[14] Over time Dr McDonald said there had been a gradual lessening in the impact of these deficits, as they had become milder. He noted Mr Waters' improved capacity to use coping strategies to minimise the impact of his deficits such as diary keeping and using GPS when driving. There was evidence of prior emotional and behavioural impairments, as noted by Dr McDonald, but Mr Waters' previous lability of mood, with a tendency to depression with outbursts of rage, has been ameliorated by his medication regime.

73. Thirdly, we are not satisfied that Mr Waters has any rateable cerebral impairment regarding aphasia and communication disorders.

74. On the CDR scale Dr Burns found memory as 0.5, one other criteria as 0.5 and four other criteria as 0.0. Page 319 of AMA 5 (bottom right column) provides:

> "If 3 or more secondary categories are given a score greater or less than the memory score, CDR = the score of the majority of secondary categories unless three secondary categories are scored on one side of M (memory) and two secondary categories are scored on the other side of M. In this case CDR = M."

75. From this definition Mr Waters CDR will be 0.0. This would give 0% WPI.

76. With regard to Mr Waters' reliance on the report of Ms Wong of 3 September 2018[15], we note that, although the report was comprehensive and well presented, it does not qualify as a relevant test pursuant to Chapter 5.9 of the Guides as there is no evidence that Ms Wong is a registered clinical neuropsychologist who is a member of the Australian Psychological Society's College of Clinical Neuropsychology, and nor is there any evidence that she is eligible for membership.

77. Of more significance is that the results of the tests Ms Wong carried out were not consistent with Mr Waters' presentation at re-examination. Further, we have some reservations as to her conclusions. As part of her testing she administered a "Test of Memory Malingering (TOMM). She said[16]:

> "Symptom Validity Testing
>
> The Test of Memory Malingering (TOMM)
>
> The TOMM is a forced choice recognition task for everyday objects. Research has shown that performance on the TOMM is relatively insensitive to neurological impairment; that is, accurate performances should occur on this test despite impaired range performance on standardised tests of learning and retention. The TOMM is sensitive to motivational defects and could accurately identify between people who were asked to simulate cognitive impairment versus the performance of those with actual impairment.

[14] Appeal Papers 165
[15] Appeal papers 37
[16] Appeal papers 42

Mr Waters' pattern of responding (T1 = 43, T2 = 42, R = 42). I acknowledge that the test manual indicates that any score below 45/50 on either Trial 2 or the Retention Trial should raise concern that the examinee is not putting forth maximum effort on this test and motivation to perform well on other tests. However I consider that Mr Waters' overall result and presentation was consistent with adequate test taking effort given that he scored in the normal range on a second test of effort.

Rey 15 Item Test

Rey's (1964) Fifteen-Item Test (FIT) is an assessment method that is reported to be sensitive in detecting malingered amnesia (Thomas J. Guilmette, Kathleen J. Neuropsychologist, Volume 8, Issue 3, 1994).

Mr Waters' performance on the Rey FIT was 14/15. His responses on this test suggest that Mr Waters was generally putting forth adequate effort to warrant interpretation of the test results."

78. Ms Wong conceded that the TOMM score revealed a pattern of sub maximal effort, but she relied on the Rey 15 Item Test score to establish that Mr Waters was generally making an adequate effort. We would observe that the 14/15 score was achieved in a test designed to detect malingered amnesia, rather than overall effort. The high score in that test tended to confirm that Mr Waters did make a sub maximal effort in the first test, and tended to indicate a degree of malingered amnesia in the second.

79. For these reasons we are unable to place any weight on the conclusions of this report regarding the effects of brain injury..

80. It follows that, having re-examined Mr Waters, and identified the relevant guidelines, that the AMS was correct in his assessment.

81. For these reasons, the Appeal Panel has determined that the MAC issued on 3 May 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