WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-2676/19**
Appellant:	**Aldi Stores (A Limited Partnership)**
Respondent:	**Luke Smart**
Date of Decision:	**5 February 2020**
Citation:	**[2020] NSWWCCMA 18**

Appeal Panel:	
Arbitrator:	**Catherine McDonald**
Approved Medical Specialist:	**Dr Michael Davies**
Approved Medical Specialist:	**Dr Robin Fitzsimons**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 23 September 2019, Aldi Stores (Aldi) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Ross Mellick and Dr Philippa Harvey-Sutton, each of whom is an Approved Medical Specialist.

2. Dr Mellick was appointed lead assessor and he issued a Medical Assessment Certificate (MAC) on 30 August 2019. The appeal related to the assessments of both assessors but this appeal deals only with the assessment made by Dr Mellick (the AMS) and the Panel was informed that the appeal with respect to Dr Harvey-Sutton's assessment will not proceed to an appeal panel. The Panel has not considered the submissions about Dr Harvey-Sutton's assessment.

3. 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.

4. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out, being that in s 327(3)(d). The Appeal Panel has conducted a review of the original medical assessment but limited to the grounds of appeal on which the appeal is made.

5. 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.

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

RELEVANT FACTUAL BACKGROUND

7. Mr Smart was employed by Aldi as a truck driver and his duties included loading and unloading trucks. On 12 September 2017, he was pulling a pallet jack loaded with stock. When the automatic brake did not work immediately on release, he was thrown off balance. His left heel went over the side of the tailgate of the truck and he fell backwards, landing on his right side and then his back, hitting his head on the ground. He fell about 1.3 metres.

8. Mr Smart was taken to Manly Hospital where a CT scan revealed a skull fracture, subdural haematoma and subarachnoid haemorrhage. He returned to truck driving after about five weeks but stopped after a couple of months when he could not handle the pace of work. Mr Smart worked on selected duties until January 2019 when he saw Dr C New, who recommended that he cease work.

9. Neuropsychological testing was undertaken by Dr M Schaffer and he was told he was not fit to drive.

10. In respect of the injuries to Ms Smart's neck and back, Dr Harvey-Sutton assessed 15% whole person impairment (WPI) comprised of 5% in his cervical spine, 5% in his thoracic spine and 7% in his lumbar spine.

11. The AMS, Dr Mellick, said that the change in Mr Smart's ability to undertake his work are in keeping with the presence of a brain injury because there were assessable abnormalities of mental status functioning, behaviour and emotion. He assessed 14% WPI in respect of mental status and 7% in respect of emotion and behaviour.

12. The total assessed WPI was 34%.

PRELIMINARY REVIEW

13. 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.

14. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because there is sufficient information in the file to deal with the appeal.

EVIDENCE

15. 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.

16. 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

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

18. In summary, Aldi sought that Mr Smart be re-examined. It submitted that the AMS did not provide any reasoning behind his "apparent decision to reject the opinion of Dr Granot". Dr Granot described the brain injury as mild and the AMS described it as significant. Aldi submitted that the AMS did not provide detailed reasoning for his assessment of 14% WPI and did not explain his reasons for making a different assessment to Dr Granot which was a demonstrable error as discussed by Harrison AsJ in *Broadspectrum (Australia) Pty Ltd v Wills*[1].

[1] [2018] NSWSC 1320.

19. Aldi also noted that Dr Granot had observed that the emotional aspects of Mr Smart's condition appeared to be improving with psychological therapy and did not appear to be a "prime driver of impairment". Aldi submitted that the AMS failed to provide reasons for his assessment and failed to explain why his assessment with respect to "emotion and behaviour" differed from that of Dr Granot.

20. In reply, Mr Smart submitted that the AMS confirmed that he had reviewed Dr Granot's report and had explained and justified his assessment.

FINDINGS AND REASONS

21. 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.

22. 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.

Method of assessment

23. When assessing Mental Status under the Guidelines, the AMS was required to apply Chapter 13 of AMA 5 as amended. Paragraph 5.4 reads:

> "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)."

24. Paragraph 5.9 reads:

> "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.

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."

25. Section 13.3d of AMA 5 says, in part:

> "The criteria for evaluating mental status and cognitive impairment are based on the amount of interference with the ability to perform activities of daily living. This information can be obtained from someone who has close and continual contact with the individual and can be documented using any one of numerous ADL indices that determine changes in activities of daily living…A tool that combines both cognitive skills and function is the Clinical Dementia Rating (CDR) which covers memory, orientation, judgment and problem solving, home and hobbies, community affairs and personal care. … Memory is considered the primary category; the other categories are secondary. If at least three secondary categories re given the same numeric score as memory then CDR=M. If three 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 and two secondary categories are scored on the other side of M. In this case, CDR=M."

26. The method of applying the CDR is set out. The criteria for rating impairment relating to mental status in Table 13-6 is based on the CDR. Class 1 with a range of 1 to 14% WPI applies where the CDR is 05.

Emotion and behaviour

27. Section 13.3f of AMA 5 describes the assessment of emotional and behavioural impairments and provides:

> "Emotional, mood and behavioural disturbances illustrate the relationship between neurology and psychiatry. emotional disturbances originating in verifiable neurologic impairment (eg stroke, head injury) are assessed using the criteria in this chapter. Psychiatric features may also exist with primary neurologic disorders. Psychiatric features can range from irritability to outbursts of rage or panic and from aggression to withdrawal."

28. Class 1 in the range 0-14% impairment is appropriate where a worker experiences "mild impairment of activities of daily living and daily social and interpersonal functioning."

The MAC

29. The AMS took a detailed history of the incident and Mr Smart's attempt to return to work. The AMS noted:

> "…Mr Smart said that he was aware that there had been a change in his driving. He reported that he was one of the best and had high standards. He felt that he was not as good as before and explained that he had, in some measure, lost his confidence. Apparently, there is a regular meeting of workers and Mr Smart volunteered that he "put his hand up" and informed his superiors he was having problems and "couldn't handle it anymore".

He was then sent to Dr Molly Schaffer, Neuropsychologist, who performed psychological tests and informed him that he was not fit to drive a vehicle.

In the interval between the time Mr Smart volunteered his lack of confidence in driving and the time the psychologist's conclusions were prepared, he was working driving forklifts loading and unloading trucks. When the psychologist's report was received, he was prevented from doing that work and no other work was offered to him. He also felt that he was not capable of doing that work safely.

However, there is some lack of clarity with regard to the history, because I am also informed that he was working up until he saw Dr New, Orthopaedic Surgeon, because of unrelated symptoms involving right-sided neck pain beginning in the anterior aspect of the neck just under the chin and extending across the top of the right shoulder and the entire length of the right upper extremity to the fingers. I am informed that Dr New was consulted because of orthopaedic symptoms and that Mr Smart was informed by Dr New that because of bulging discs in the cervical region and also elsewhere in the spine, he should not be working.

The history I was given is that Mr Smart ceased working, not because his employers insisted that he stop but because of the advice given by Dr New in relation to cervical symptoms and MRI scan findings. Since the end of January 2019, Mr Smart has been at home and unemployed."

30. The AMS recorded Mr Smart's present symptoms:

"The present symptoms involve soreness in the posterior parietal region on the right side, the right occipital area and in the left frontal region when he is in "fast moving" situations.

Mr Smart described his symptoms as follows: The soreness lasts for up to ten minutes. The two areas of soreness are also associated with headache which occurs approximately once or twice a week. The headache is in the left frontal region. It responds to Panadol and is not associated with vomiting, impaired vision or photoptic phenomena. There is also a complaint of impaired memory.

Mrs Smart contributed to the history and indicated that even if she writes a list of things for Mr Smart to buy, that errors are still made and that she "needs to go with him" because he cannot be relied upon to remember what to buy or to carefully buy what she writes down. He also has to be reminded about things that are to be done because of the impaired retentive memory. His distant memory is intact.

It is also noted that his close relationship with the community has changed and now he is very much a loner. He previously was very interested in a number of things, including golf, enjoyed exercising on a regular basis and surfing. He has however abandoned these various tasks and hobbies. His judgement is impaired and Mrs Smart does not allow him now to pay bills or to make decisions of moment for the family.

Although he has not specifically become lost, Mr Smart reports that he sometimes has to struggle to cope with orientation in some places and Mrs Smart confirms that she is aware that sometimes he struggles to know where he is.

There is no problem with regard to his personal hygiene.

There is also impairment of emotion and behaviour. Although he is not physically violent, he is very "short on the trigger" and is verbally aggressive to wife in a way that he had not been previously. Others have also remarked about this. This is of sufficient severity that it has changed relationships with family and friends. The mood disorder has also placed stresses on the relationship.

Mr Smart said that he is sometimes aware when he is angry and struggles to stop it. He also said that he generally feels very bad after it that the remembers what he does and generally apologises.

A significant change has also been reported regarding Mr Smart's personality. He said that he now feels that he is "anal…a perfectionist". As an example of this, Mrs Smart indicates that when she puts the groceries in the pantry, she must put all the labels in perfectly symmetrically, facing forward, otherwise Mr Smart will become angry. If a cushion is not straight, he again finds it disturbing. She reports "…it bothers him." It places considerable extra stress on her household duties."

31. The AMS set out his findings on physical examination and his review of two MRI scans, which showed a pre-existing lesion of long-standing. He set out his summary of injuries and diagnoses:

> "This gentleman suffered a serious head injury on 12 September 2017 with MRI evidence of intracranial bleeding and a cerebral contusion. He provides history of a change with regard to his ability to do his pre-injury work. The observations made by him are in keeping with the presence of a brain injury occasioned on 12 September 2017.
>
> There are assessable abnormalities of mental status functioning and behaviour and emotion without any evidence of pre-existing cognitive or behavioural problems. He has also reported disordered behaviour in relation to excessive obsessionality and depression of mood associated with insomnia, which responded in some measure to a period of psychotherapy. These symptoms were not present prior to the injury in question and are of psychiatric significance and should be regarded to necessitate psychiatric assessment as part of the medical assessment following this serious head injury.
>
> The pre-existing lesion in the brain stem should not be regarded to be contributing in any significant way to the symptoms and abnormalities documented above.
>
> I am to make an assessment of neurological function due to a brain injury. I would also suggest that there are symptoms which are not explicable as a result of the neurological injury and indicate depression and severe obsessionality requiring a psychiatric assessment."

32. The AMS provided his comments on other medical opinions. He disagreed with Dr C New that another MRI scan and cognitive testing were required. He said:

> "… in addition to the MRI evidence, there is evidence based on the clinical assessment which provides ample basis for a whole person impairment assessment to include impairments due to a brain injury. AMA5 and the WorkCover Guidelines indicate that a neuropsychological assessment is not a necessary component of the evidence enabling that to be done.
>
> It is noted that Dr Ron Granot, Neurologist, made an assessment of Mr Smart in his report of 17 April 2019. He records details of the injury including loss of consciousness and, under the heading of "Current Status" on page 4, he records clear details pointing to significant mental status impairment, including poor judgement such that he is no longer able to pay bills adequately. Dr Granot also records MRI evidence of a haemorrhagic contusion in the left temporal lobe in addition to a left sided subdural and a subarachnoid haemorrhage in the MRI scan of 12 September 2017."

33. In respect of Mr Smart's nervous system, the AMS assessed 14% WPI in respect of mental status and 7% in respect of emotion and behaviour.

34. The AMS did not set out his reasons for making that assessment other than to refer to paragraphs 5.1, 5.4 and 5.9 of the Guidelines and Tables 13-5, 13-6 and 13(d) of AMA 5.

35. The AMS set out his findings and his conclusions but did not set out his reasoning process and in failing to so do has made a demonstrable error, requiring the Panel to undertake a review. The error is not, as Aldi submitted, the failure to explain why he did not agree with Dr Granot.

Medical evidence

36. The medical evidence - in both the Application to Resolve a Dispute and the Reply - is scant and there is limited material from Mr Smart's treating doctors.

37. Mr Smart described his condition at paragraphs 18 to 20 of his statement dated 28 May 2019:

> "With regard to my traumatic brain injury, I feel a constant groggy and heavy sensation on the left side of my head. I have difficulty with getting all my words out and remembering what the conversation is about. I therefore have trouble keeping up in a conversation and require prompting or repetition of what is being said. This is frustrating and I know that I am not keeping up but cannot do anything about it. I have become self conscious and don't feel like leaving the house unless my wife is with me. My confidence has been affected greatly.
>
> I now suffer anxiety. When I experience anxiety, I feel a tingling sensation at the fracture site of the back of my head. I also experience this sensation if I am in a fast paced environment.
>
> I feel I have lost my independence and that I have to rely on others, mainly my wife to assist in daily activities and reminding from her with a number of things as I tend to forget a lot. I therefore require a calendar which assists in prompting me of important dates. I also have become short tempered which affects my relationships. This is particularly upsetting as I know its effect however, I cannot help my reactions and it is not until after I snap that I am able to stop and calm down."

38. Mr Smart described the change in his level of physical activity – before the injury he was active and enjoyed golf, surfing, weight training, running and gardening. He is now only able to walk for exercise because he suffers fatigue but said that he had also lost confidence. He described the disappointment of being unable to return to truck driving, which was his "passion."

39. Mr Smart relied on a report by Dr C New, orthopaedic and spinal surgeon, dated 25 October 2018. Dr New examined Mr Smart's orthopaedic injuries and said:

> *"Brain* - I have not performed any brain function tests although it is apparent that he does have some short term memory loss and some slurring of his speech. He has difficulty in remembering particular words, even in my consultation today. He should have a cognitive impairment test to see whether he has a minor or moderate brain injury. He will also require a follow up MRI of his brain and brain stem."

40. Dr New provided an impairment assessment in a report dated 4 February 2019 which he said should be added to the assessment made by Dr Schafer.

41. Mr Smart was then examined by Dr M Schafer, neuropsychologist, who reported on 16 November 2018. She noted that a mild intellectual disability was diagnosed when Mr Smart was at school. She set out the tests she administered and diagnosed a "complicated mild to moderate traumatic brain injury."

42. Dr Schafer set out her assessment:

> "I have assessed the impact of Mr Smart's TBI using section 13.3d 'Mental Status, Cognition and Highest Integrative function' of the AMA Guides. Using Table 13-5 'Clinical Dementia Rating' scale, I have classified him as having a CDR score of 1.0 or Class 2 Impairment of the Whole Person. The CDR score equalled the score of the majority of subcategories since three subcategories fell on one side of memory while the other two equalled memory. The score breakdown is as follows : he had no memory impairment (CDR score of 0); his orientation and Personal Care were intact (CDR scores of 0 each); Community Affairs was slightly impaired due to diminished work capacity (CDR score of 0.5); Home and Hobbies was mildly impaired with respect to gardening (CDR score of 1.0); his Judgement and Problem Solving were impaired due to executive dysfunction (CDR score of 2.0). It is my opinion that Mr Smart's WPI is 18% as most of his CDR scores fall toward the lower end of the range (see Table 1 below).
>
> Using section 13.3f and Table 13-8, 'Criteria for Rating Impairment Due to Emotional or Behavioural Disorders,' I have assessed the degree of WPI as a result of the behavioural and emotional sequelae of Mr Smart's TBI. According to Mr Smart, he was experiencing stress and anxiety at work. Ms Smart noted that her husband demonstrated behavioural difficulties at home including increased irritability and inflexible thinking. It is my impression that these behavioural changes had a mild limitation on his activities of daily living and interpersonal functioning. They were assessed as having a 7% WPI, which is in the middle of the Class 1 range (see Table 1 below)."

43. Dr Schafer's assessment with respect to mental status is difficult to understand when her assessment of memory is zero but some of the secondary categories are quite high. Her assessment does not accord with Section 13.3d of AMA5.

44. Dr R Granot, neurologist, reported to Aldi's lawyers on 17 April 2019. He briefly reviewed the report of Dr Schafer and noted other documents. He described Mr Smart's current status, summarising the history obtained from Mr Smart and his wife. His examination findings were:

> "The Mini Mental Examination score was 30/30. He required Prompt for 1 recall. There was a slowness of processing, but recall was reasonable. Neurological examination was otherwise unremarkable, without focal signs or features of raised intracranial pressure. Lumbar flexion and back pain were limiting as he dressed himself."

45. Dr Granot's opinion was:

> "Mr Smart sustained a significant head injury as per the SIRA guidelines as evidenced by the neuro-imaging changes (MRI and CT) and thus qualifies to be assessed according to the guidelines for a traumatic brain injury.
>
> His memory has been affected as have his activities of daily living to an extent by this, although he was able to work (in modified duties) and function day-to-day at a level that is commensurate with a mild degree of impact. I note that he was working and managing well until told to stop working by Dr New.
>
> Further, I note that his pain is a factor in his being able to complete his hobbies and other work, which is not assessable in this report, but also has no bearing on the functional impact of his brain injury."

46. His diagnosis was “mild traumatic brain injury.” His assessment of permanent impairment was:

> “As stated above, given his abnormal CT and MRI brain at the time of injury, he can be assessed as having suffered a traumatic brain injury.
>
> Using table 13-5 of AMA5, p319, he best fits into CDR 0.5 = class 1 impairment, with memory (which is the noted to be the prime driver of the CDR category) showing consistent slight forgetfulness but a defect that is in all benign - he certainly forget tasks and during conversations, but is able to recall with time and tests reasonably, though with some delay in processing. Other impairments are Orientation = none; Judgment and Problem Solving = slight impairment; Community affairs – slight impairment in that he has difficulty interacting and engaging fully in conversations; Home and hobbies are reduced, but I feel this is related to pain and spinal issues rather than intellectual impairment; Personal care = none - fully capable, except for difficulties related to pain.
>
> This places him into Class 1 Whole Person Impairment, which, given the primacy of memory, I would place into the mid-higher range, 8% WPI. I do not believe there is need to deduct for pre-existing conditions, though note there was a premorbid mild intellectual disability, this was not (apparently - according to his history and that of his wife) impacting on activities of daily living as required to assess him under the above table.
>
> Emotional aspects appear to be improving with psychological therapy. They do not appear to be a prime driver of impairment at this stage.”

Consideration

47. The AMS set out Mr Smart’s current symptoms in a way that corresponds to the application of the CDR table. His error was in failing to set out the reasoning leading from the symptoms recorded to his assessment of 14% for mental status and 7% for emotion and behaviour. The error is not, as submitted by Aldi, a failure to explain why his assessment differed from that of Dr Granot. In *State of NSW v Kaur*[2], Campbell J said:

> “In *Wingfoot Australia Partners Pty Ltd v Kocak* [2013] HCA 43; 252 CLR 480, the High Court of Australia dealt with the nature of the jurisdiction exercised by a medical panel under cognate Victorian legislation. The legislation is not entirely the same but it is broadly similar in purpose. Allowing for some differences, the High Court said at page 498 [47]:
>
> > ‘The material supplied to a medical panel may include the opinions of other medical practitioners, and submissions to the Medical Panel may seek to persuade the Medical Panel to adopt reasoning or conclusions expressed in those opinions. The Medical Panel may choose in a particular case to place weight on the medical opinion supplied to it in forming and giving its own opinion. It goes too far, however, to conceive of the functions of the panel as being either to decide a dispute or to make up its mind by reference to completing contentions or competing medical opinions. The function of a medical panel is neither arbitral or adjudicative: It is neither to choose between competing arguments nor to opine on the correctness of other opinions on that medical question. The function is in every case to perform and to give its own opinion on the medical question referred to it by applying its own medical experience and its own medical expertise.’
>
> Not all of this, as I have said, is apposite in the context of the New South Wales legislation. In particular it is obvious that approved medical specialists are required to decide disputes referred to them by the process of medical assessment. Even so, it is

[2] [2016] NSWSC 346.

not necessary that approved medical specialists should sit as decision makers choosing between the competing medical opinions put forward by the parties. Essentially, the function is the same as that described by the High Court in *Wingfoot Australia*. That is to say, their function is in every case to form and give his or her own opinion on the medical question referred by applying his or her own medical experience and his or her own medical expertise. It is sufficient, as their Honours pointed out at [55], that:

> 'The statement of reasons… explain the actual path of reasoning in sufficient detail to enable the Court to see whether the opinion does or does not involve any error of law.'"

48. Having found that the AMS was in error in failing to set out his reasoning, the Panel has undertaken a review based on the history recorded at the time of the examination by the AMS and the documents in the file. The Panel is conscious that its task is to consider the material and form its own view and not to fill in the gaps in the AMS's assessment.[3]

49. With respect to memory, the AMS noted that Mr Smart has impaired memory. Even if his wife writes a shopping list, he makes errors. He requires reminding about things to be done because of his impaired retentive memory. His distant memory is intact. Those findings are consistent with Mr Smart's statement.

50. Those findings are also consistent with a score of 0.5 ("consistent slight forgetfulness; partial recollection of events; 'benign' forgetfulness") but bordering on the criteria for a score of 1.0 ("moderate memory loss; more marked for recent events; defect interferes with everyday activities").

51. The AMS recorded that Mr Smart struggles to cope with orientation in some places, confirmed by his wife's observations. This is also consistent with a score of 0.5 ("fully oriented except for slight difficulty with time relationships") but bordering on the criteria for a score of 1 (" moderate difficulty with time relationships; oriented for place at examination; may have geographic disorientation elsewhere.")

52. Similarly, with respect to judgement and problem solving, Mr Smart reported impaired judgement and that his wife does not permit him to pay bills or make important decisions for the family, consistent with a CDR rating of 0.5.

53. With respect to community affairs, Mr Smart has become a loner, consistent with a slight impairment and a CDR rating of 0.5.

54. With respect to home and hobbies, Ms Smart has abandoned his previous interests in golf, exercise and surfing, consistent with a slight impairment and a rating of 0.5.

55. Mr Smart has no impairment with respect to personal hygiene, rating 0.

56. As set out in Section 13.3d of AMA 5, Mr Smart's CRD score is 0.5 and the range of impairment is 1 to 14%. In some of the categories, including the primary category of memory, the score is bordering on 1 and it is therefore appropriate to assess him at the high end of the range and determine 14% WPI.

57. With respect to emotion and behaviour, the history obtained by the AMS, supported by Mr Smart's own statement supports an assessment in class 1 – "mild limitation of activities of daily living and daily social and interpersonal functioning." The AMS recorded that Mr Smart is verbally aggressive to his wife. He is sometimes aware that he is angry and struggles to stop and often feels very bad later. He has become a perfectionist and becomes angry if household items are not neatly ordered.

[3] See *Broadspectrum (Australia) Pty Ltd v Wills* [2018] NSWSC 1320.

58. These changes are significant. Mr Smart's statement in May 2019 and his history to the AMS on 1 August 2019 confirm they are ongoing. Dr Granot's statement that emotional aspects appear to be improving with psychological therapy is not supported by other material in the file and the history taken by Dr Granot is merely that Mr Smart has undergone psychological treatment. The history recorded by the AMS was that psychological treatment resulted in some improvement in Mr Smart's mood. That is not inconsistent with the ongoing symptoms recorded, which result from the head injury.

59. It is appropriate to assess Mr Smart in the middle of class 1, resulting in 7% WPI. This assessment avoids the risk of double compensation because of an overlap with the assessment in respect of mental status.

60. For these reasons, the Appeal Panel has determined that the MAC issued on 30 August 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*.

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 Number: **2676/19**
Applicant: **Luke Smart**
Respondent: **Aldi Stores (a limited partnership).**

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 Ross Mellick 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 the Guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA 5 Guides**	**% WPI**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Sub-total/s % WPI (after any deductions in column 6)**
1.Cervical spine	12 September 2017	Chapter 4 pp24-30	Chapter 15 Table 15-5 p392	5%	0	5%
2.Thoracic spine	12 September 2017	Chapter 4 pp24-30	Chapter 15 Table 15-4 p389	5%	0	5%
3.Lumbar spine	12 September 2017	Chapter 4 pp24-30	Chapter 15 Table 15-3 p384	7%	0	7%
4.Mental status	12 September 2017	Chapter 5, paragraphs 5.1, 5.4 and 5.9	Chapter 13, Section 13.3d Tables 13-5 and 13-6, pp 320 to 321	14%	0	14%
5.Emotion and behaviour	12 September 2017	Chapter 5, paragraphs 5.1, 5.4 and 5.9	Chapter 13, Section 13.3f Table 13-8	7%	0	7%
Total % WPI (the Combined Table values of all sub-totals)					**34%**	

Catherine McDonald
Arbitrator

Dr Michael Davies
Approved Medical Specialist

Dr Robin Fitzsimons
Approved Medical Specialist

5 February 2020

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*.

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