WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-5049/19**
Appellant:	**Penelope Edwards**
Respondent:	**Secretary, Department of Education**
Date of Decision:	**4 May 2020**
Citation:	**[2020] NSWWCCMA 84**

Appeal Panel:	
Arbitrator:	**R J Perrignon**
Approved Medical Specialist:	**Dr Michael Davies**
Approved Medical Specialist:	**Dr Michael Fearnside**

BACKGROUND TO THE APPLICATION TO APPEAL

1. The appellant worker, Ms Edwards, appeals from the Medical Assessment Certificate of Approved Medical Specialist Dr Fitzsimons dated 17 January 2020.

2. On 29 January 2010, Ms Edwards fell at work and hit her head on the floor, causing an intracranial haemorrhage in the left occipital lobe, which caused an impairment of her right sided vision in both eyes (homonymous hemianopia).

3. By consent of the parties, the Registrar referred the following body systems to approved medical specialists for assessment of whole person impairment as a result of injury on 29 January 2010:

    (a) Nervous system (brain) – to Dr Fitzsimons as lead assessor.

    (b) Visual system – to Dr Wechsler.

4. By her Medical Assessment Certificate dated 17 January 2020, lead assessor Dr Fitzsimons assessed a 14% whole person impairment (9% visual system, 5% nervous system – brain). This reflected the assessments made of the relevant body system by each of the two assessors in accordance with their respective referrals.

5. Ms Edwards appeals only from Dr Fitzsimons' assessment of 5% (nervous system – brain), on the basis that it demonstrates error.

6. On 23 March 2020, the Registrar by his delegate was satisfied that the ground of demonstrable error was made out in respect of Dr Fitzsimons' findings as to "the contribution of the appellant's psychological issues to her cognitive impairment".

7. On 23 April 2020, the Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (4th edition) (the Guidelines).

Submissions

8. The Appeal Panel has had regard to the written submissions filed by both parties. It is unnecessary to set them out here in full, but appropriate to summarise them as follows.

9. The appellant employer submits that the Medical Assessment Certificate of Dr Fitzsimons demonstrates error, for the following reasons:

    (a) The approved medical specialist erred in finding that pre-existing depression and microvascular disease were primarily responsible for, and a major contributor to, clinical dementia pre-existing depression and microvascular disease were primarily responsible for, and a major contributor to, clinical dementia: submissions at [3-4].

    (b) The approved medical specialist erred in finding at [10a] that pre-existing depression precluded an assessment of emotional or behavioural status due to brain injury.

    (c) The approved medical specialist erred in finding that the deterioration of the appellant's memory and cognitive (impairment) resulted from depression and microvascular disease rather than from injury.

    (d) The approved medical specialist failed to consider the appellant's 'profound history of acquired dyslexia post head injury' which was identified by Dr Wechsler.

10. The appellant observes at [3] that it is not the role of the approved medical specialist to 'make decisions and findings on injury', but fails to allege that the approved medical specialist has done so, describe how she did so or how she erred in doing so. This is not articulated in a manner capable of being construed as a separate ground of appeal.

11. The respondent submits in reply as follows.

    (a) The Registrar referred the nervous system (brain) to Dr Fitzsimons for assessment of whole person impairment. In accordance with par 1.6b of the Guides, Dr Fitzsimons provided a diagnosis, namely left occipital lobe haemorrhage with right visual field defect consequent upon the fall.

    (b) She found that the most significant contributor to the appellant's disability and debility was the visual field defect. That was assessed by Dr Wechsler.

    (c) It was open to the approved medical specialist to conclude, as she did, that the appellant's cognitive issues resulted primarily from pre-existing depression and relationship issues.

    (d) Dyslexia was taken into account by Dr Wechsler in making his assessment. It was not an appropriate parameter for Dr Fitzsimons to take into account in making hers.

Reasoning of the Approved Medical Specialist

12. Dr Fitzsimons examined the appellant on 16 December 2019. She took a history of injury on 29 January 2010 and its sequelae, consistent with the summary above, in greater detail.

13. Under the heading, '*present symptoms'*, Dr Fitzsimons recorded at [4]:

> "Her visual (field) difficulty (being separately assessed) from the haemorrhage means that "letters disappear" from what she is reading. This has only happened since the accident. Her "brain makes up words" when she misses seeing them. She had to re-train in some activities which she had mastered before the accident - such as knitting. She still drops a lot of stitches. She said she is "very good at not finishing projects", and has about five knitted items not finished - including a "beautiful baby shawl", because she can't find the pattern of triangles to finish it.
>
> She has spent "thousands and thousands and thousands" of dollars (about $40,000) on crafting beads which she has not yet used. These beads fill up her garage and are on many trolleys and book-cases.
>
> She does not like going out at all - and normally does so only with her visiting care-workers or carer. She may go with her care worker to Coffs Harbour. ….
>
> She describes her memory as "sometimes very good, sometimes very bad". There are occasions when she can't think of the next word. She may forget to take her tablets. Her long-term memory is good. "Sometimes my brain seems to be fishing".
>
> She continues to drive, and had in fact driven for three quarters of an hour before catching a train from Mulgrave Station to Sydney prior to the consultation as part of the trip to get here. There was no problem with this. She sometimes gets lost, "but soon gets back on track" (I did not think the description she gave indicated a greater need to check whereabouts than do normal members of the population). She tries to get to appointments on time During the time after the accident when she had returned to teaching she would normally get to lessons on time without a problem.
>
> She continues to have a problem because of slow reading and writing. If she gets to a long word and is unsure how it ends she may make it up - eg saying "parachute" instead of "passionfruit". She may miss reading all the numbers on a price tag.
>
> She uses a computer, but has to do a lot of corrections if she types a wrong letter. She knows the basics. She has been to Vision Australia, and tried the suggested prisms.
>
> She doesn't wash every day - only when Paul is around to hassle her to have a shower. She did have a couple of episodes of swoony dizzy falls in the shower in July 2019.
>
> She complains of some right orbital/ supraorbital pain and "sparkles" coming down in front of her right eye/. Her treating ophthalmologist, Dr Sanbach, said that this was due to a retinal detachment. She is not sure exactly when it came on.
>
> She thought that her left lip drooped a bit after the accident, but she is not worried about this and it does not affect her speech.
>
> She doesn't cook or do anything much at home. She says this is "because I don't want to". Paul does the shopping. …"

14. Under the headings, '*details of any previous or subsequent accidents'*, and '*general health'*, she recorded at [4]:

> "She does not think she was depressed before the accident- "not badly anyway - just fed up". However, there is quite extensive GP documentation of depression and hypertension around 2005/2007/2008.

Diabetes mellitus was diagnosed in 2008. She has had gastric banding for obesity, and takes a statin for high cholesterol levels.

… She has a history of high blood pressure, diabetes, high serum cholesterol, and documented episode(s) of prior depression."

15. On examination at [5], Dr Fitzsimons found 'no objectively identifiable cognitive deficits'. She described a number of simple tests which she had administered at interview, the results of which supported this finding. She identified no objective abnormality in the distribution of the supraorbital nerves, no facial asymmetry beyond normal, no facial muscle weakness. Deep tendon reflexes were symmetrical if slow, save for the ankle reflexes with reflex detected in the right ankle but not the left. She could not identify consistent visual field deficit, but deferred to the more accurate measurements of Dr Wechsler in this regard.

16. Dr Fitzsimons referred at [6] to a considerable number of reports and scans.

17. She diagnosed at [7]:

> "left occipital lobe haemorrhage with right visual field defect (residual inferior quadrantinopia), consequent upon the fall, in the context of known high blood pressure.'

18. Dr Fitzsimons reasoned as follows at [7] – emphasis added:

> "As Dr Wechsler has noted that this right sided visual field defect would significantly impair her ability to read, as it affects scanning across a page and word.
>
> **I consider this field defect (which has been assessed by Dr Wechsler and others) to account entirely for her difficulties in reading and writing, and probably other tasks such as knitting, which involve seeing down and to the right. There is no separate aphasia.**
>
> I also consider the residual right inferior field defect, which has been defined and plotted by Dr Wechsler, to be the most significant physical manifestation of her brain injury, and much the most significant organic accident-related contributor to her disability and debility.
>
> The occipital lobes are the part of the brain dedicated to registering sight, and they do so in a very geometric fashion - so that, for instance, the upper aspect of the left occipital lobe will register the inferior right visual field of vision.
>
> It is perfectly possible and not at all uncommon for a patient with pathology restricted to an occipital lobe to have no more general neurological or cognitive manifestations, which is not to say that other intricate brain connectivities may not sometimes be affected. **Subtle changes (and not-so-subtle changes) may be extremely difficult to distinguish from the effects of depression and other factors on speed of processing and memory**.
>
> The fact that her [Glasgow Coma Score] was 14/15 in the ambulance, rising to 15/15 when seen at hospital argues against there being likely significant long term cognitive deficits. Likewise, the absence of "significant medically verified PTA [post traumatic amnesia]" means that her long-term prognosis in relation to memory should be good. (I do not consider the Registrar's comments of a possible few minutes PTA to be significant, and indeed she did have good recall of events surrounding the accident).

It is clear that her senior treating specialist - Dr Kathleen McCarthy, Brain Injury Rehabilitation Specialist, Westmead Hospital, definitely did not think that she would have long term cognitive consequences of brain injury (see quotes above). Dr Alexander Walker, the neuropsychologist who conducted the early neuropsychology tests, was of much the same opinion, although she did note a minor relative difficulty with visual as opposed to auditory memory (which could be construed as consistent with occipital lobe haemorrhage). Most subsequent neuropsychologists expressed a similar opinion, although Dr Pegum (October 2017) reported some apparent deterioration and some apparent improvement in subdomains since 2010.

She undoubtedly has had multiple vascular risk factors (including hypertension, high cholesterol, diabetes mellitus and obesity) **for brain microvascular disease, and these rather than her haemorrhage would be responsible for any progression in cognitive deterioration since the accident.**

Taking these various reports and factors together, including the pre-accident documentation, **I consider that her depressive symptoms and emotional/relationship issues which were particularly manifest at school and which were certainly present before the accident are likely to be primarily responsible for her present cognitive issues, with a contribution from microvascular/brain ischemic factors to any progression**, and that these factors interacted with her personal situation at the school/workplace."

19. We interpret this reasoning to mean that, in the opinion of the approved medical specialist:

    (a) the right sided visual field defect, which was assessed by Dr Wechsler, resulted from brain injury and caused reading difficulties;

    (b) that defect was the most significant contributor to her current impairment, and

    (c) any progression of impairment since the injury has been caused, not by injury, but by pre-existing depressive symptoms and vascular risk factors.

20. Notwithstanding these findings, Dr Fitzsimons did find there was cognitive impairment as a result of brain injury, assessing it at 5% whole person impairment in the manner described below at [22], making no deduction for a pre-existing condition or disorder.

21. Dr Fitzsimons did not rate permanent impairment due to emotional/behavioural status. She gave the following reasons at [10]:

    "The corpus of documentation cited above indicates that her emotional/depression situation is of long-standing, and antedates the accident. It is not due to direct physical consequences of the brain injury, and there is therefore no assessable impairment for emotional/behavioural status due to brain injury."

22. Dr Fitzsimons then assessed whole person impairment (nervous system) by applying Chapter 13 AMA5, as required by the *Guidelines*, Chapter 5. She rated impairment by reference to AMA5 Table 13-5 (Clinical Dementia Rating). No objection to this course has been taken on appeal. She explained her ratings as follows at [10] - emphasis added:

    "I would assess the following under the CDR, Tables 13-5 and 13-6, p 320, AMA5. In assessing the CDR due to the accident I am mindful of both her current presentation and the documentation/neuropsychological testing in the first year after the accident.

    Memory = 0.5. Functional memory in the aftermath of the accident was at most marginally and partially impaired (see results of Dr Walker), and specifically for visual and not auditory memory Any subsequent deterioration in memory and cognition is related to other factors, such as microvascular disease and ongoing depression.

Orientation = 0. Has been generally well orientated in time. Occasional lapses in place were not, as described, beyond normal limits of functioning.

Home and Hobbies - 0.5. Tends to give up - eg with her craft work. (This is likely at least in part at to be due to her visual field defect, separately assessed). Doesn't do much cooking (could relate to depression). Has lost friends. Taken together I consider these data consistent with 0.5 category due to brain lesion.

Judgement and Problem Solving. = 0.5. Massive overspending on craft beads etc, although this likely at least in part reflects depression. However Dr Walker's tests indicate well preserved planning and reasoning abilities.

Community Affairs = 0.5 Questionable. Has lost friends. No persuasive evidence of change. Runs monthly market stall. Incidents with personal interactions before and after accident.

Personal Care = 1.0. Requires prompting

This computes to a CDR of 0.5 (1-14% WPI), 319, col 2, AMA5. The 0.5 subcomponents of the CDR are headed "questionable" in Table 13-5, AMA5 - which reflects the fact that the borderzone of the descriptions with normality is indistinct**. I consider that she qualifies towards the lower end of this scale, because many of the decisions regarding whether the CDR components were 0.5 rather than 0 were borderline, given the extent of an undoubted major contribution from unrelated emotional factors including depression (not due to physical effects of brain injury) to an extent which is difficult to define**. **Further, it was apparent that the neuropsychology testing of Dr Walker in 2010 (which, being proximate to the accident, are likely to reflect greater accident-related deficits than later testing) revealed most functions of memory to be intact, although there was some apparent impairment of visual memory (but not auditory memory) and speed of processing. *There was good preservation of concentration, planning and reasoning* (my italics), which strongly argues against there being major errors of judgement or problem solving due to physical brain injury.**"

23. A clinical dementia rating of 0.5 fell within a Class 1 impairment, for which Table 13-6 prescribed a range of 1% to 14% whole person impairment. For the reasons extracted above, the approved medical specialist assessed a 5% whole person impairment (nervous system), being a little below the mid-range allowable in that class.

Ground (a) – Finding that vascular risk factors and pre-existing depression were the main cause of dementia

24. The approved medical specialist was obliged by the Registrar's referral to assess permanent impairment of the nervous system, to the extent the impairment resulted from injury. To do that, she had to determine what part of the observed impairment, if any, resulted from injury. Not only did Dr Fitzsimons have power to determine whether the whole or any part of the impairment so resulted, she was obliged to do so.

25. She exercised that power by determining that only part of the current cognitive impairment resulted from injury. She gave detailed reasons (above) for finding that any deterioration in the applicant's mental condition (apart from her visual field defect) since the immediate aftermath of injury was likely to be due, not to injury itself, but to pre-existing depressive symptoms and vascular risk factors.

26. In our view, that conclusion was well open to her on the evidence. We can identify no error.

Ground (b) – Alleged failure to assess emotional or behavioural status

27. Chapter 13 of AMA5 requires the assessor to assess the most impaired of four categories. They are state of consciousness and level of awareness, mental status and integrative functioning, use and understanding of language, and behaviour and mood: par [13.2].

28. Having found, as she did, that the only permanent impairment resulting from injury was the visual field defect, the only course available was to assess impairment by reference to mental status and integrative functioning. She did this by constructing a clinical dementia rating in accordance with Table 13-5.

29. It would have been an error to assess by reference to behaviour and mood. The approved medical specialist did not err in this regard. This ground of appeal fails.

Ground (c) – Alleged finding that deterioration in memory and cognitive impairment resulted from depression

30. This ground of appeal in part repeats ground (a) above. For reasons indicated above, we consider it was well open to the approved medical specialist to find, as she did, that deterioration in the appellant's cognitive impairment was due to factors other than injury.

31. The appellant also alleges that memory was not assessed. That allegation is mistaken. Memory is among the six factors assessed as part of the Clinical Dementia Rating (Table 13-5). As the approved medical specialist explained at [10] of her certificate (extracted above), memory loss was assessed at 0.5 on the CDR. The criteria for that are: "consistent slight forgetfulness, partial recollection of events; "benign" forgetfulness".

32. The appellant does not suggest that an assessment of 0.5 was not reasonably open. In our view, it was plainly open to the approved medical specialist. For all these reasons, we can identify no error, and this ground fails.

Ground (d) – alleged failure to consider 'profound history of acquired dyslexia post head injury'

33. As indicated, the approved medical specialist found that the worker's reading difficulties resulted from the right visual field defect. She did not find that it resulted from any other condition caused by brain injury. She found specifically that there was no aphasia.

34. Dr Fitzsimons assessed impairment by constructing a Clinical Dementia Rating in accordance with Table 13.5. The appellant does not allege that the use of Table 13-5 as a tool for assessment was itself erroneous. For reasons given above, we consider the use of Table 13-5 as the assessment tool was entirely appropriate and in accordance with the Guides. Table 13-5 lists six matters for individual assessment. They are: memory, orientation, home and hobbies, judgment and problem solving, community affairs, and personal care.

35. The appellant does not in terms suggest that the existence of reading difficulties caused by the visual field defect was a matter relevant to the assessment of any of the six factors in Table 13-5, nor demonstrate why that should be. In assessing the category, 'home and hobbies' at 0.5, the approved medical specialist relied on the tendency of the appellant to give up, for example on her craft work. She noted in passing this was probably due in part to the visual field defect assessed by Dr Wechsler, but did not on that account ignore the tendency to give up, either in whole or in part. She relied on it in assessing that category. In our view, it was appropriate for her to take that characteristic into account when assessing home and hobbies. She did so. We are not satisfied that she discounted it in any way due to the separate assessment of Dr Wechsler.

36. Having assessed a total CDR of 0.5, the approved medical specialist selected a score of 5% whole person impairment which, as we have noted, was a little below the mid-range of that allowable, being 1%-14%. She gave detailed reasons for doing so at [10], quoted above. Those reasons were patent, and justified a selection of 5% whole person impairment.

37. In the circumstances, we are not satisfied that the approved medical specialist failed to consider reading difficulties caused by the visual field defect when constructing a clinical dementia rating pursuant to Table 13-5. On the contrary, she made specific reference to it when assessing 'home and hobbies'. We are comfortably satisfied that, to the extent relevant, it was taken into account. This ground also fails.

Conclusion

38. For the reasons given, the appeal is dismissed, and the Medical Assessment Certificate of Dr Fitzsimons dated 17 January 2020 is 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*.

G Bhasin

Gurmeet Bhasin
Dispute Services Officer
As delegate of the Registrar