WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-4807/19**
Appellant:	**Darryl Rodney Brown**
Respondent:	**Active Energy Pty Ltd**
Date of Decision:	**20 May 2020**
Citation:	**[2020] NSWWCCMA 90**

Appeal Panel:	
Arbitrator:	**John Wynyard**
Approved Medical Specialist:	**Dr Michael Fearnside**
Approved Medical Specialist:	**Dr Robin Fitzsimons**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 16 January 2020, Darryl Brown, the appellant, lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr John O'Neill, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 20 December 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. Following Consent Orders made on 22 November 2019 the delegate of the Registrar referred this matter to an AMS on 28 November 2019 for an assessment of WPI caused to the "head" and the cervical spine, by an injury on 8 September 2016.

7. Mr Brown was employed by the respondent as a labourer/trade assistant at all relevant times.

8. On 8 September 2016, whilst climbing the steps of his truck to an elevated work platform the appellant hit his forehead on a steel bar. He experienced immediate pain and climbed back down to the ground where he sat down. A fellow employee asked if he was alright and after a while he continued his work

9. By 17 September 2016, he complained to his general practitioner (GP) that he had poor attention and concentration, headaches, shooting pains from the neck and low back pain. He was given Endone.

10. Further consultations with the GP were held and Mr Brown eventually attended the Emergency Department at Orange Base Hospital on 26 September 2016 complaining of headaches and giving a history that he had hit his head on a metal pole "multiple times". He was noted as a very poor historian.

11. An x-ray of the cervical spine and a CT of the brain were organised by Mr Brown's GP. The x-ray of the cervical spine showed spondylotic changes from C3/4 to C6/7 and the brain scan was normal.

12. On 25 October 2016, the GP had commenced Mr Brown on antidepressant medication.

13. On 9 January 2017, an MRI scan of the brain was found to be normal.

14. Further investigations were carried out by CT scan of the cervical spine on 12 May 2017 which confirmed the original x-ray findings of spondylotic changes.

15. Mr Brown was referred to Dr Bell, Orthopaedic and Spinal Surgeon on 25 July 2017 where no abnormality was found and Dr Bell recorded that Mr Brown was complaining mainly about a frontal chronic headache.

16. Mr Brown saw a different GP, Dr Bo, from 30 March 2017 and he was referred to Dr Emma Blackwood, Consultant Neurologist, on 10 January 2018.

17. Dr Blackwood also took a history of chronic headache. She diagnosed post traumatic migraine headaches. Dr Blackwood organised MRI and MRV brain scans and an MRI of the cervical and thoracic spine which occurred on 6 June 2019. The brain investigations were normal and the MRI again confirmed spondylotic changes in the cervical spine.

18. The MRI of the cervical spine was reviewed on 30 September 2019 by Dr Ron Schnier, Radiologist, as there was thought to be present an abnormal cervical cord signal at T2, which was thought to show hypersensitivity.

19. Mr Brown was referred to Dr Peter Ashkar on 27 November 2017 for a neuropsychological assessment. Dr Ashkar found no evidence of brain injury or injury-related cognitive impairment. The findings suggested that Mr Brown had a preoccupation with his health concerns and a tendency to develop physical symptoms in response to stress. Personality factors also were said to contribute to the appellant's sense of poor health.

20. The AMS found there to be nil WPI in relation to the injuries to both the head and the cervical spine.

PRELIMINARY REVIEW

21. 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.

22. The appellant sought to be re-examined by a Panel AMS. No re-examination was called for as we did not find that the AMS had fallen into error.

EVIDENCE

Documentary evidence

23. The Appeal Panel has before it all the documents that were sent to the AMS for the original medical assessment and has taken them into account in making this determination.

Medical Assessment Certificate

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 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 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.

Ground 1 - incorrect criteria

28. The appellant submitted that the AMS had applied incorrect criteria in finding that the head injury was not of a kind that would be expected to give rise to any permanent impairment of cognitive function.

29. Under "Present Symptoms" the AMS recorded[1]:

> "Mr Brown said he had a chronic headache. It was felt across the forehead. It varied in severity. It was worse with stress and exercise and he thought beer also made it worse so he largely gave up drinking alcohol. It was better when he lay down.
>
> He could not be certain of his medications. He was pretty sure he was on Lovan 20mgs mane and Endep 50mgs nocte. He was on another medication prescribed by Dr Blackwood for headache prevention – possibly Topiramate.
>
> He said he tried to avoid analgesic medication for pain and would only occasionally take a couple of Panamax if the headache was bad.
>
> His next complaint was of chronic 'ringing in the ears'.
> On specific questioning, he told me he still had 'a sore neck'. He said it would come and go. He said the neck was 'crunchy'.
>
> Again, on specific questioning, he told me that he was 'a bit vague. I can misplace things. I often leave the hotplate on'.

[1] Appeal papers pages 22-23.

Mr Brown said he lived with his older brother who was a truck driver. He said he managed his own finances. He said he would drive a car from time to time. He said he was withdrawn from social activities but would occasionally go to the TAB 'to see old mates'. He had largely lost interest in his hobbies of woodwork and fixing old lawnmowers because 'I get angry if things don't go right'."

30. The AMS said in his summary[2]:

> "Mr Brown sustained a minor head injury in the work incident of 8 September 2016.
>
> This is not the type of head injury which would be expected to give rise to any permanent impairment of cognitive function (NSW Workers' Compensation Guidelines 2016, Point 5.9, page 32).
>
> In keeping with this statement, no cognitive impairment was detected at neuropsychological assessment on 27 November 2017.
>
> Also in keeping with a minor head injury was the fact that cerebral CT and MRI brain scans were normal.
>
> As far as I am concerned Mr Brown's post-accident headaches have always been of tension type. I do not believe there were ever any migrainous features. Mr Brown was unhappy with his workplace prior to the accident on 8 September 2016 and has a documented depressed mood from at least soon after the accident.
>
> There is no impairment of the central nervous system (brain) as a consequence of the incident.
>
> Mr Brown said he felt neck pain at the time of the accident on 8 September 2016 and headache, neck pain and chronic low back pain were all reported at the time of Mr Brown's attendance at Orange Base Hospital on 26 September 2016.
>
> At no stage has neck pain been associated with limitation of range of movement of the neck and certainly today there was a normal range of movement with no muscle guarding, spasm or asymmetry of neck movement.
>
> At no stage was neck pain associated with symptoms or signs of cervical radiculopathy or myelopathy and review of cervical spine imaging has shown no substrate for any cervical cord lesion.
>
> Radiological studies have shown chronic degenerative spondylotic changes between C3/4 and C6/7 as might be expected in a person of Mr Brown's age and with a history of chronic arthritis.
>
> Chronic neck symptoms have best fit with DRE Cervical Category 1 (AMA5, Table 15.5, page 392) with nil whole person impairment.
>
> In short, from a neurological viewpoint, Mr Brown has sustained no impairment of the brain, neck or spinal cord (central nervous system) as a consequence of the work accident of 8 September 2016."

31. In considering the opinion of other medical practitioners, the AMS discussed the report of Dr Paul Teychenne who had found on 14 August 2019 that Mr Brown suffered from a 28% WPI, from a mild concussive traumatic brain injury and an incomplete cervical cord lesion.

[2] Appeal papers page 24.

32. The AMS said[3]:

> "For the reasons I gave above, Mr Brown has no symptoms, signs or radiological evidence of either traumatic brain injury or incomplete cervical cord lesion and I totally disagree with Dr Teychenne."

Appellant's submissions

33. The criteria that had been incorrectly applied were said by the appellant to have been, firstly, those contained in Chapter 5.9 of the Guides. These had been incorrectly applied because, the appellant said, the AMS had noted that no cognitive impairment was detected at the neuropsychological assessment on 27 November 2017. The guideline however stipulated that a neuropsychological report was not to be considered in isolation, but in the context of the overall clinical history, examination and neurological findings. It was submitted that the AMS "did not pay regard" to the overall clinical history, as his finding that Mr Brown's headaches were tension headaches was contrary to the evidence that they were migrainous in nature. The overall history as recorded by Dr Blackwood, Dr Teychenne and indeed the appellant himself contradicted the findings by the AMS that there never were any migrainous headaches.

34. Secondly, the appellant submitted that "when one considers the MAC as a whole" the AMS failed to consider Chapter 13 of AMA 5. Chapter 13 is entitled "The Central and Peripheral Nervous System."[4] Reference was made to Chapter 5.5 of the Guides and it was alleged that sections 13.5-13.6 of AMA 5 were accordingly relevant. It was further alleged that sections 13.5-13.6 included Table 13.5, which the AMS had not considered.

35. It was further submitted, "consistent with AMA5," that the AMS did not "give consideration" to Mr Brown's memory loss, his difficulty in handling problems and his impairment of function at home. It was submitted that the AMS had obtained evidence regarding those factors when questioning Mr Brown, and that they were also considered in the evidence lodged before the AMS.

36. The appellant referred to the AMS's finding that there were "no inconsistencies" of presentation to ground a submission that incorrect criteria had accordingly been used. The application of correct criteria would have resulted in a finding that Mr Brown had suffered impairment in relation to his brain injury, it was put.

Respondent's submissions

37. The respondent submitted that the duty of the AMS was to make an assessment based on his findings on physical examination and his knowledge and experience within the terms of the WorkCover Guides. The respondent submitted that the AMS was not bound to accept at face value the medical evidence provided, but was required to make a determination that was in accordance with the whole of the medical evidence in clinical findings before him.

38. The respondent referred to Chapter 5.9 of the Guides and submitted that the AMS had made a comprehensive review of the history and used his experience to determine that the injury sustained was not the type of head injury that would be expected to give rise to any permanent impairment of cognitive function.

39. Further, the respondent submitted, none of the three alternative criteria set out in Chapter 5.9 were present in Mr Brown's case.

[3] Appeal papers page 25.
[4] AMA 5 page 305.

Ground 2 - demonstrable error

Appellant's submissions

40. Mr Brown also submitted that the AMS had made a demonstrable error. Mr Brown relied on the evidence of Dr Paul Teychenne, and in particular that Dr Teychenne had found (in his report of 12 December 2018):[5]

> "As noted in my experience, an incomplete cervical cord lesion may be associated with memory deficit and there is evidence that spinal cord lesions may cause major deficits in cerebral areas as a result of external damage."

41. Mr Brown submitted that Dr Teychenne was unambiguous in stating that there had been a decrease in the range of movement of Mr Brown's neck on examination. Mr Brown referred to findings by other medical practitioners that there was chronic neck pain with bilateral radiculopathy. Reference was also made to the CT scan of Mr Brown's cervical spine of 12 May 2017, which noted the pathology mentioned by the AMS.

42. Mr Brown then submitted that the AMS had been incorrect in finding that there had been no limitation in the range of movement with the neck. The AMS had further fallen into error in finding that there had been no neck pain or associated symptoms or signs of cervical radiculopathy or myelopathy. His finding that imaging had shown no substrate for cervical cord lesion was also said to be incorrect.

43. It was submitted therefore that the AMS had failed to grapple with the evidence lodged.

Respondent's submissions

44. The respondent submitted that the AMS had properly considered Dr Teychenne's assessment. The respondent referred to the examination carried out by the AMS which showed no relevant abnormality and submitted, uncontroversially, that an AMS is not required to rely upon outdated clinical evidence from treating doctors, or the opinions of other medical commentators such as Dr Teychenne.

45. The respondent submitted that the AMS had given sound reasons as to why he disagreed with Dr Teychenne.

DISCUSSION

The referral

46. We note the terms of the referral which sought an assessment of the "head" and cervical spine. We would observe that there is no guideline published regarding the assessment of injuries to the head. Part 5.6 of the Application to Resolve a Dispute (ARD) sought an assessment of WPI of "the central and peripheral nervous system," and the AMS dealt with this issue by saying "after referral to the Certificate of Determination dated 22 November 2019, I assessed whole person impairment with respect to the central nervous system (head and spinal cord) and cervical spine."[6]

47. Within this definition, the AMS found that the appellant suffered "0%" WPI, a finding which creates some theoretical difficulty, in that such an outcome implies that there was a traumatic brain injury which satisfied the threshold criteria set out at paragraph 5.9 for assessment of mental status and other cerebral impairments in the NSW Guides and was assessed pursuant to the Clinical Dementia Rating scale ("CDR") at Tables 13.5 and 13.6 of AMA 5.

[5] Appeal papers page 68.
[6] Appeal papers page 20.

It is clear that the AMS was satisfied that the criteria at paragraph 5.9 were not satisfied. It follows that there was no rateable traumatic brain injury. His finding of 0% did not imply that the provisions of Table 13.5 had any application to Mr Brown's case.

The applicable guidelines

48. There was some confusion apparent from the appellant's submissions as to the appropriate method of assessment. In referring to Chapter 5.5 of the Guides, the appellant was incorrect. Sections 13.5-13.6 of AMA 5 are relevant to Chapter 5.5. Chapter 5.5 is not the relevant guideline in Mr Brown's case. because it is concerned with hemiplegia, monoplegia and upper or lower limb impairment due to the effects of brain injury. Mr Brown has none of those conditions.

49. Further, the appellant is incorrect to suggest that Table 13.5 is relevant to sections 13.5-13.6 of AMA 5. Tables 13.5 and 13.6 are relevant to the disturbances described in Chapter 5.9 of the Guides, which contain the threshold criteria in Mr Brown's case, in so far as it relates to a traumatic brain injury.

50. Chapter 5.9 of the Guides provide:[7]

> "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."

51. The neuropsychometric testing was carried out by Dr Ashkar, whose report found:[8]

> "17. The findings from this assessment provide no evidence of brain injury or injury-related cognitive impairment to limit Mr Brown's capacity for employment (and this is supported by his normal CT brain and MRI brain scans). He performed at (and in some cases above) premorbid estimates in almost all areas of his intellectual and cognitive functioning assessed. He demonstrated minor weaknesses in aspects of higher level/executive thinking Involving planning and organisation and source monitoring of material , which contributed to inefficiencies In his memory, but these are not caused by any damage to his brain (and are indicative of his pre-injury functioning or his relatively minor symptoms of anxiety and depression uncovered on this assessment)."

[7] Guides page 32.
[8] Appeal papers page 189.

52. Where the threshold criteria in paragraph 5.9 are first satisfied contained within the Section 13.3 (d) of AMA 5 named by Chapter 5.9 are various scales for assessment of the disturbances therein identified. However, in the light of Dr Askar's report and the contemporaneous information regarding the chronology following the injury, the issue was whether the blow to the head on 8 September 2016 caused a rateable traumatic brain injury.

The impact

53. It is to be noted that a pre-requisite for assessment under Chapter 13 of AMA 5, is evidence of a severe impact to the head, or the involvement of a high energy impact. The AMS found that the accident of 8 September 2016 caused a "minor head injury" which was "not the type of injury which would be expected to give rise to any permanent impairment of cognitive function."[9]

54. Apart from being mentioned in the preamble to his submissions as to incorrect criteria, this finding was not specifically addressed by the appellant. In his statement of 4 July 2017, Mr Brown described the incident as follows:[10]

> "18. On 8 September 2016, I had been instructed to clean an elevated work platform. This a hydraulic platform used to raise workers so they can reach to the top of telegraph poles.
>
> 19. To access some parts of the machine I would mount it by using some steps which are part of the machine. When I got to the platform level there is boom which is made of steel.
>
> 20. I recall that on 3 occasions I hit my head on the boom but on the fourth time I hit my head particularly hard against the boom. I recall a severe pain in my head. On all the occasions I hit the boom with my forehead."

55. Although he was suffering headaches "on and off"[11], Mr Brown kept working until he saw Dr Chen at the same practice as his GP, Dr McRae, on 17 September 2016 complaining of headaches and neck pain. He then sought medical treatment at Orange Base Hospital on 26 September 2016, and he first consulted his then GP, Dr McRae, on 29 September 2016, according to his clinical notes.[12]

56. The entry in the discharge summary from Orange Base Hospital described Mr Brown as a "poor historian" who had been off work for a week with back pain. The summary noted that Mr Brown was complaining of headache and some neck pain. No limitation in movement of the neck was complained of.[13]

57. The history of the injury taken by the AMS was consistent, although he took a history of one blow, he noted the discharge summary from the Orange Base Hospital that indicated there had been several times that Mr Brown had hit his head.

58. We agree that this history is not commensurate with the description in the Guides of a severe or high impact to the head - nor is it the typical type of head injury that would lead to cognitive deficit in the experience of the Panel medical experts. There was no significant medically documented abnormality of the Glasgow Scale Score, no significant medically verified post-traumatic amnesia and no abnormality on neuroradiological investigation. Accordingly, the appellant has failed to establish that his injury on 8 September 2016 was a traumatic brain injury.

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[9] See paragraph [29] above.
[10] Appeal papers page 40.
[11] Appeal papers page 365.
[12] Appeal papers page 321.
[13] Appeal papers page 162.

The three criteria of Chapter 5.9

59. Even if the impact were of such force, Mr Brown then had to show that on clinical assessment he exhibited at least one of the three dot point criteria set out in Chapter 5.9. As indicated there was no suggestion that Mr Brown had suffered a loss of consciousness, and no Glasgow Coma Scale score was taken. Neither was there any suggestion in the evidence that Mr Brown suffered from post-traumatic amnesia. The appellant did not assert that he suffered such signs and symptoms.

60. The third criterion is that clinical assessment must include significant intracranial pathology on CT scan or MRI. The AMS found that the cerebral CT and MRI brain scans were normal. Dr Teychenne did not address this requirement.

Dr Teychenne's diagnoses

Mild concussive traumatic brain injury

61. Notwithstanding the above, the appellant relied upon the opinion of Dr Teychenne to demonstrate that the AMS had erred in his assessment. Dr Teychenne's diagnoses were as follows:[14]

> "'It was apparent that Mr Brown sustained a work-related injury during the course of his employment. He most probably had pre-existing degenerative cervical spondylosis with disc osteophytes abutting and potentially compressing the cord, but as a result of a probable hyperextension injury to his neck when he struck his head on a metal bar he sustained an incomplete cervical cord lesion.'
>
> *2. Which body parts have been impaired as a result of the injury, the subject of the claim?*
>
> As a result of this impact, he also sustained a mild concussive traumatic brain injury."

62. Although Dr Teychenne made a diagnosis that Mr Brown had suffered a "mild concussive traumatic brain injury," he made no reference to Chapter 5.9 of the Guides in either of his reports, which totalled 19 pages. It is of particular note that in his diagrammatic certificate of WPI, the column for the identification of the relevant chapter, page and paragraph number of the Guides is blank.[15] (Dr Teychenne has also referred to the incorrect edition of the Guides in that column).

63. Thus, although Dr Teychenne found there was a 15% WPI by reference to the CDR scale in Table 13.5 of AMA 5, his conclusion must be rejected. As we have indicated, no abnormal Glasgow Coma Scale score was medically verified, and there was no post traumatic amnesia. Dr Teychenne did not suggest that the cerebral CT scan or MRI of the brain showed any intracranial pathology, and accordingly no traumatic brain injury had been established pursuant to the dot point criteria in Chapter 5.9. The assessment he made pursuant to Table 13.5 of AMA 5 thus was of no weight.

Incomplete cervical cord lesion

64. We reject this diagnosis. Dr Teychenne is the only medical expert to suggest that Mr Brown had suffered an incomplete cervical cord lesion. Dr Teychenne's findings on examination, some two years after the event, must be viewed with some caution, as mild imbalance, motor neuron weakness within the upper limbs, intrinsic hand muscle weakness, and some weakness in dorsi flexion of the toes were not found by Dr Blackwood, who like

[14] Appeal papers page 70.
[15] Appeal papers page 81.

Dr Teychenne and Dr Mellick is also a Consultant Neurologist. On 8 May 2018, Dr Blackwood found that neurological examination of the upper limbs was within normal limits with regard to tone, power, reflexes, sensation and coordination.[16] No other medical practitioner identified the findings on examination made by Dr Teychenne.

65. With regard to the radiological evidence, Dr Teychenne stated:[17]

> "The findings on MRI scan of the cervical spine were quite consistent with Mr Brown sustaining an incomplete cervical cord lesion secondary to a hyperextension injury to the neck."

66. In a supplementary report of the same date, 14 August 2019, Dr Teychenne said:[18]

> "I reviewed the MRI scan of the spinal cord and there appeared to be evidence of T2 hyperintensity extending from about *C5* to C6. This also appeared to be apparent on the axial view.
>
> I would suggest that you go back to the MRI scan unit and ask them to review the MRI scan looking for any evidence ofT2 hyperintensity within the areas that I have indicated."

67. This suggestion was taken up by the respondent, who obtained a report from Dr Ron Schnier dated 30 September 2019. Dr Schnier reviewed the MRI scan, and said:[19]

> "On the mid sagittal slice on the T2 weighted sequences, apparent central T2 hyperintensity in the cord is thought to be artefact. This is not confirmed on the axial view, the axial view showing a further area of artefact in the right side of the cord rather than in the same position. On the oblique coronal views through the cervical cord on the T2 weighted sequences there is no abnormal cord signal.
>
> The visualized portion of the thoracic cord is normal. There is multilevel spondylotic change but no canal narrowing or nerve root compressive lesion is seen in the thoracic spine. There are small mid thoracic disc herniations.
>
> COMMENT
> 1. Apparent area of T2 hyperintensity in the cord is thought to be artefact.
> 2. Multilevel spondylotic change and exit foraminal narrowing."

68. The medical experts on the Panel confirm that an artefact is a finding of no clinical significance. Accordingly, the radiological basis for Dr Teychenne's diagnosis is unproven, and undermines an opinion which, in view of Dr Teychenne's belated suggestion that a further review of the MRI scan be undertaken, we find to have been tentative in any event.

The neuropsychological report

69. Dr Peter Ashkar provided a neuropsychological report on 14 December 2017, and it was in respect of this opinion that the appellant referred generally to the provisions of Chapter 5.9. It was suggested that the AMS had applied incorrect criteria because he had accepted the report of Dr Ashkar that no cognitive impairment was detected, when the guideline required that the neuropsychological test data was not to be considered in isolation, but in the context of the overall clinical history, examination and radiological findings.

[16] Appeal papers page 88.
[17] Appeal papers page 79.
[18] Appeal papers page 84.
[19] Appeal papers page 373.

70. We reject that submission. We have reproduced the summary given by the AMS, and it is clear that although he referred to, and accepted the report of Dr Ashkar, he did not do so in isolation. He also referred to his clinical examination, the history he obtained as to the mechanism of the injury, the relevant past history, the relevant radiology, and to other reports - particularly that of Dr Ross Mellick, Consultant Neurologist, with whom he agreed.

The nature of the headaches and Mr Brown's complaints

71. It was submitted that the AMS "did not pay regard" to the overall clinical history, as his finding that Mr Brown's headaches were tension headaches was contrary to the evidence that they were migrainous in nature. The overall history as recorded by Dr Blackwood, Dr Teychenne and indeed the appellant himself was said to contradict the findings by the AMS that there never were any migrainous headaches. As we understood the submission, this alleged error could be relied upon to cast sufficient doubt on the whole of the AMS's findings to establish that he fell into error.

72. Allied to that submission was an allegation that the AMS did not "give consideration" to the complaints made by Mr Brown, which we have reproduced at the outset of these reasons. The appellant conceded that the AMS had questioned Mr Brown, but asserted that he then ignored the memory loss he had been told about.

73. These submissions must be rejected. In the first place there is no evidence that the AMS "did not pay regard" to the overall clinical history, nor is there any evidence that the AMS did not "give consideration" to Mr Brown's complaints.

74. The appellant has asked the Panel to draw an inference that, because of a disagreement as to the nature of the headaches, and his disregard of Mr Brown's complaints, the AMS has failed to give proper attention to the evidence before him. In doing so, the appellant has ignored the presumption of regularity that attends the actions of administrative decision makers.[20] Whilst presumptions are rebuttable, there is no evidence the appellant has pointed to that would demonstrate that the AMS has not read and considered the evidence before him.

75. Secondly, the error to which the appellant points is of minor relevance. Whether the headaches were of a migrainous type or not does not assist the appellant in his challenge to the MAC. No WPI is assessable for migrainous headaches, and neither does a migrainous headache constitute a criterion that the sufferer has suffered a traumatic brain injury pursuant to Chapter 5.9 of the Guides.

76. Similarly, an AMS is not bound to accept the complaints made to him by the claimant. The appellant did not establish that he had sustained a traumatic brain injury due to his failure to meet the necessary criteria. His subjective impressions were of no probative value when those criteria were objective in nature.

77. Thirdly, with regard to the nature of the headaches, a minor error of this nature, even had it been made, would not invalidate the whole of the findings of the AMS, which were detailed, considered and clear in their explanation.

78. In any event, we do not agree that the premise of the submission regarding the nature of the headaches is made out.

[20] See *Bojko v ICM Property Service Pty Ltd* [2009] NSWCA 175 at [36]: *Jones v Registrar WCC* [2010] NSWSC 481 at [36] per James J.

79. To examine the evidence relied on by the appellant, firstly Dr Emma Blackwood, Consultant Neurologist, supplied three reports dated 3 May 2018, 17 July 2018 and 2 November 2018. In her report of 3 May 2018 she diagnosed "a post-traumatic chronic daily headache with migraine features."[21] She prescribed appropriate medication. On review on 17 July 2018, Dr Blackman noted that although the medication had improved Mr Brown's sleep, he was still complaining of the headaches. Dr Blackwood prescribed increased medication to address the headaches.[22] When she next assessed Mr Brown on 2 November 2018, Dr Blackwood recorded a history of continuing headaches. She noted that neurological investigation was essentially normal, and that the CT scan of the brain was also normal. She noted that the headaches fulfilled the diagnostic criteria for chronic migraine, and thought that Mr Brown "most likely" suffered a concussion after the injury.

80. The medical experts on the Panel note that the medication prescribed by Dr Blackwood was appropriate for treatment of post traumatic migraine, but that it failed to ameliorate Mr Brown's condition. This failure is an indication that Mr Brown's headaches were not of a migrainous type.

81. Further, we were not assisted by the appellant's reference to Mr Brown's own version of events. We note he was recorded as not being a good historian, and that his GP, Dr McRae, had recorded on 24 November 2015 that he been consulted on a number of occasions regarding "significant conflict at work." Dr McRae said that this was "certainly impacting on Mr Brown's day to day well-being." We note further the reference in the discharge summary from Orange Base Hospital that Mr Brown had the week off work prior to his attendance on 26 September 2016 "due to back pain." This appears to conflict with Mr Brown's account in his statement that he was able to resume work immediately after the injury, and that he did not make any complaints about headaches or neck pain until nine days after the accident.

82. These matters, whilst perhaps not being significant in themselves, nonetheless are relevant in considering the probative weight that can be applied to Mr Brown's subjective account. The history of conflict at work prior to the injury and his depressed mood soon after, against the background of Mr Brown being a poor historian, raises the question of whether his recollections were entirely objective. The inconsistencies as to whether Mr Brown took time off work for an unrelated back problem as recorded by the hospital, cast some doubt on his statement that he continued to work for nine days before seeing Dr Chen for his headaches, and in any event raises questions as to the seriousness of the headaches he said he was suffering during that time. We found Mr Brown's statement to be of little probative weight.

83. We have already considered the reports of Dr Teychenne, and note that he relied on Dr Blackwood's opinion that the headaches were of a migrainous nature.

Summary

84. It is trite law that an AMS is required to use his expertise and clinical experience to reach an independent decision as to the matters referred to him. His task is, as submitted by the respondent, to make a determination that was in accordance with the whole of the medical evidence and his clinical findings. He is not obliged to accept any medical opinion that has been put before him and his reasons, as we have earlier indicated, need not be extensive or detailed. The AMS in the present case has given extensive and clear reasons, notwithstanding.

85. It follows that we find no application of incorrect criteria, nor any demonstrable error. We confirm the MAC, with the rider that in confirming a 0% finding for the "head" (for which, as indicated, there are no guidelines in either the Guides or AMA 5), we confirm the finding of the AMS that no traumatic brain injury had been established.

[21] Appeal papers page 88.
[22] Appeal papers page 90.

86. For these reasons, the Appeal Panel has determined that the MAC issued on 20 December 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*.

L Funnell

Leo Funnell
Dispute Services Officer
As delegate of the Registrar