WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

Issued in accordance with section 294 of the *Workplace Injury Management and Workers Compensation Act 1998*

Matter Number: **3375/20**
Applicant: **Agnieszka Dodd**
Respondent: **Qantas Airways Ltd**
Date of Determination: **21 July 2020**
Citation: **[2020] NSWWCC 249**

The Commission determines:

Finding

1. The applicant has 15% whole person impairment resulting from injury on 29 January 2018.

Order

2. The respondent pays the applicant compensation pursuant to s 66 of the *Workers Compensation Act 1987* in the sum of $37,282.50 which includes an uplift pursuant to s 66(2A).

JOHN HARRIS
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF JOHN HARRIS, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

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Lucy Golic
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Ms Agnieszka Dodd (the applicant) is employed by the Qantas Airways Ltd (the respondent) and sustained a compensable injury to the lumbar spine on 29 January 2018.

2. The applicant commenced proceedings claiming permanent impairment compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act). The body parts for assessment are the lumbar spine and the skin.

3. The essential facts are not in dispute.

4. The applicant sustained injury to her lumbar spine when she was seated in the crew "jump seat" on a flight from Melbourne to Sydney. The landing was described as a "very heavy 'thud". Shortly after leaving the seat and whilst disarming a door, the applicant felt a sharp pain in her lower back.

5. An MRI scan undertaken shortly after the accident showed significant pathology at L5/S1. The applicant underwent a left L5/S1 discectomy and rhizolysis on 15 May 2018.

6. The applicant was assessed by Dr Bodel and Dr Harrington. The only difference in their opinions was whether the skin should be assessed at 0% or 1% whole person impairment (WPI) and whether there should be an allowance for the effects on the activities of daily living (ADLs).

Proceedings before the Commission

7. The matter was listed for telephone conference on 17 July 2020 when Mr Counter appeared for the applicant and Ms Haddock appeared for the respondent. The applicant requested that the assessment issue be determined consistent with the decision of the President of the Workers Compensation Commission (Commission) in *Etherton v ISS Properties Services Pty Ltd*[1] (*Etherton*). The respondent submitted that the matter be referred to an Approved Medical Specialist (AMS).

8. The documentation admitted into evidence at the telephone conference without objection was:

    (a) Application to Resolve a Dispute and attachments (Application), and
    (b) Reply and attachments (Reply).

9. The parties were given the opportunity to make oral submissions. I indicated to the parties that I would consider the position as to whether I would determine the extent of the degree of WPI. I have concluded that this is an appropriate case due to the similarity in assessments made by Dr Bodel and Dr Harrington. The differences in their opinions can be resolved by analysis of the deficiencies in the reports or upon the application of facts from other materials including specialist treating reports.

[1] [2019] NSWWCCPD 53.

EVIDENCE

Applicant's statement

10. The applicant provided a statement dated 25 May 2020. She described her current symptoms as more severe than prior to surgery consisting of significant left buttock and thigh pain and a constant dull ache across the back with shooting pains down the left leg to the foot. From time to time the applicant suffers episodes of severe low back pain which can take days to settle down.

11. The applicant stated that she was a "very social and active person" but could no longer engage in her favourite past times "such as boating or jet skiing" which aggravated the back pain.[2]

12. The applicant stated that she struggled with household chores and maintenance and her husband "assists with these tasks now".[3]

Treating opinions

13. An MRI scan dated 31 January 2018 was reported by Dr Ahamed as showing a large posterior central/left protrusion at L5/S1 impinging upon the descending left S1 nerve root.[4]

14. An MRI scan dated 2 December 2019 is reported by Dr Carter as showing distortion of the cauda equina nerve roots from L4 to S1 suggestive of intra-thecal arachnoid adhesions.[5]

15. On 15 May 2018, Dr Winder performed a laminotomy to expose the left S1 nerve root and observed a "significant lateral disc protrusion compressing the nerve root."[6]

16. In November 2018, some six months following surgery, Dr O'Neill, Neurologist, noted ongoing back pain and numbness down the leg and into the left foot in the S1 distribution. He opined that the symptoms were a "manifestation of scar tissue".[7]

17. A recent report from treating surgeon Dr Winder dated 16 December 2019 noted that a recent MRI scan showed some arachnoiditis and clumping of the distal nerve roots. The doctor opined that there was an unnoticed dural breach at some point which has caused irritation.[8]

Qualified opinions

18. Dr Bodel was qualified by the applicant and provided a report dated 15 January 2020.[9] After setting out the undisputed history, Dr Bodel noted that recent scans showed the applicant had developed arachnoiditis in the lower sacral segments which was a complication from the surgery.

19. Dr Bodel noted the applicant had persisting sharp, shooting pain and neurogenic pain down the left leg with a constant dull ache across the low back. There were occasional episodes of severe spasm.

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[2] Application, p 6.
[3] Application, p 6.
[4] Application, p 17.
[5] Application, p 39.
[6] Application, p 61.
[7] Application, p 50.
[8] Application, p 36.
[9] Application, p 8.

20. The doctor noted that the applicant was an active person and used to enjoy jet skiing "which she can no longer do".[10] The applicant reported struggling with household maintenance and cleaning activities.

21. Dr Bodel assessed the applicant as DRE lumbar category III with an additional 3% for ongoing radiculopathy following surgery and a mildly complicated surgical scar assessable at 1%. The doctor allowed 2% for the effects on the activities of daily living because they were "moderately compromised".[11] Dr Bodel's overall assessment was 16% WPI.

22. Dr Chris Harrington was qualified by the respondent and provided a report dated 10 March 2020.[12] The doctor recorded a history that current symptoms were worse than before surgery with significant back and left buttock/thigh pain.

23. Dr Harrington noted that the L4/5 [sic L5/S1] discectomy produced a "small midline scar". He assessed the applicant as DRE lumbar category III due to the spinal surgery with ongoing radiculopathy. This amounted to 13% WPI.

24. In respect of ADLs, Dr Harrington opined:[13]

> "There is no adjustment for daily living as her husband does the yard maintenance etc."

25. Accordingly, Dr Harrington made no allowance for the scar or the effects on the activities of daily living and assessed the applicant at 13% WPI. He made no deduction pursuant to s 323 of the 1998 Act.

REASONS

26. The assessment of WPI is undertaken in accordance with the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (fourth edition guidelines).[14] The fourth edition guidelines adopt the 5th edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairment* (AMA 5). Where there is any difference between AMA 5 and the fourth edition guidelines, the fourth edition guidelines prevail.[15] The fourth edition guidelines have been held to have the force of delegated legislation.[16]

27. The medical evidence clearly establishes that the applicant suffered injury to at least the L5/S1 disc resulting in the need for surgery by way of left L5/S1 discectomy and rhizolysis. A recent MRI scan has revealed distortion of the cauda equina nerve roots from L4 to S1 suggestive of intra-thecal arachnoid adhesions.

28. The applicant continues to complain of significant lumbar spine pain and left sided radiculopathy.

29. Both Dr Harrington and Dr Bodel agree, and I accept, that the applicant should be assessed at DRE lumbar category III and an allowance made for residual symptoms and radiculopathy in accordance with Table 4.2 of the fourth edition guidelines.

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[10] Application, p 11.
[11] Application, p 16.
[12] Reply, p 1.
[13] Reply, p 5.
[14] The 4th edition guidelines are issued pursuant to s 376 of the 1998 Act.
[15] Clause 1.1 of the fourth edition guidelines.
[16] *Ballas v Department of Education* [2020] NSWCA 86 at [97].

30. The doctors agree and I accept that the impairment is permanent and maximum medical impairment has been attained and that there should be no deduction pursuant to s 323 of the *Work Injury Management and Workers Compensation Act 1998* (the 1998 Act).

31. The only difference in the respective assessments are whether there should be an allowance for the effects on the activities of daily living and whether the surgical scar should be assessed at 1% WPI.

Activities of Daily Living

32. Paragraphs 4.33 – 4.36 of the fourth edition guidelines relate to the assessment of an appropriate percentage for the activities of daily living. Paragraph 4.33 provides that an "assessment of the effect of the injury on ADL is not solely dependent on self-reporting but it is an assessment based on all clinical findings and other reports".

33. Paragraph 4.34 provides that the diagram "should be used as a guide" in determining the appropriate percentage. There can be no doubt about the significance of the word "guide" as the fourth edition guidelines has used bold print to emphasise the word.

34. Paragraph 4.35 provides that the base impairment is increased by:

- 3% WPI if the worker's capacity to undertake personal care activities such as dressing, washing, toileting and shaving has been affected;
- 2% WPI if the worker can manage personal care but is restricted with usual household tasks, such as cooking, vacuuming and making beds, or tasks of equal magnitude, such as shopping, climbing stairs or walking reasonable distances, and
- 1% WPI if the worker can manage personal care and household tasks but is unable to get back to previous sporting or recreational activities.

35. The history provided by the applicant relates to the effects on home care and the loss of social and recreational activities.

36. The assessment of the effects on ADL is not solely based on self-reporting. The medical evidence clearly establishes post-surgical consequences of severe back pain and left sided radiculopathy.

37. The applicant has consistently reported an inability to return to previous sporting and recreational activities. Further, her evidence is that she has difficulties with household activities. I accept the applicant's consistent history of her ongoing difficulties and her inability to undertake social activities and difficulties with household tasks. The applicant's complaints are clearly consistent with the ongoing pain and restrictions, the recent MRI scan, and Dr Winder's recent report.

38. Based on that correct history, Dr Bodel assessed 2% WPI for ADLs.

39. Dr Harrington has not recorded a history of the restrictions with social and recreational activities. Furthermore, his statement that he assessed 0% for ADLs because the husband does the yard maintenance does not address the correct criteria and otherwise does not say what the applicant cannot do by reason of her injury.

40. I am satisfied, accepting the applicant's evidence and the opinion of Dr Bodel, that the nature of the injury to the lumbar spine and the ongoing pain restrictions satisfies an allowance of 2% for ADLs consistent with paragraph 4.35 of the fourth edition guidelines.

Skin

41. The applicant has a surgical scar. The applicant's statement unfortunately does not address the relevant matters for consideration under Table 14.1 of the fourth edition guidelines. There is no photograph showing the scar in the materials filed in the Commission.

42. There are no specific details provided by Dr Bodel as to why the scar is assessed at 1% WPI.

43. Given its position in the lower lumbar spine, the scar would be not be clearly visible with usual clothing.

44. The applicant bears the onus of proving the extent of any permanent impairment. There is little if any evidence addressing the criteria under Table 14.1 of the fourth edition guidelines as to why the scar should be assessed at 1% WPI.

45. Table 14.1 of the fourth edition guidelines provides that the determination is based on a "best fit". Further, paragraph 14.6 of the fourth edition guidelines is consistent with my view that an "uncomplicated scar for standard surgical procedures" does not of themselves, rate as an impairment.

46. Given the absence of how Dr Bodel assessed 1% WPI, I am satisfied that the scar should be assessed at 0%. In this respect I agree with Dr Harrington's opinion.

Assessment

47. Given the nature of the surgical procedure, the duration of symptoms and the common medical opinion expressed by Dr Harrington and Dr Bodel, I am satisfied that the assessment is permanent, and the applicant has reached maximum medical improvement.

48. The applicant has a 15% WPI of the lumbar spine based on DRE lumbar category III, 2% for ADLs and a further 3% for ongoing radiculopathy[17]. There is no s 323 deduction[18] and a 0% WPI for the skin. The combined assessment is 15% WPI.

CONCLUSION

49. The finding and order are set out in the Certificate of Determination.

[17] See *Robbie v Strasburger Enterprises Pty Ltd* [2017] NSWSC 363 at [34].
[18] The respondent bears the onus of proof on establishing a s 323 deduction: *Matthew Hall Pty Ltd v Smart* [2000] NSWCA 284 at [32].