WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-3371/19**
Appellant:	**Thomas Elmes Racing**
Respondent:	**Sally Waters**
Date of Decision:	**13 March 2020**
Citation:	**[2020] NSWWCCMA 53**

Appeal Panel:	
Arbitrator	**John Wynyard**
Approved Medical Specialist:	**Dr Robin Fitzsimons**
Approved Medical Specialist:	**Dr Sophia Lahz**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 30 September 2019, Thomas Elmes Racing, the appellant employer lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Ross Mellick, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 5 September 2019 he issued an amended MAC on 9 September 2019 to correct a typographical error.

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 a reference to whole person impairment.

RELEVANT FACTUAL BACKGROUND

6. On 17 July 2019, a delegate of the Registrar referred this matter for a WPI assessment of the nervous system as a result of injury on 30 March 2016.

7. Ms Waters (the respondent) was employed as a stable hand with the respondent. On 31 March 2016, she was injured when she was thrown off a horse and suffered a traumatic brain injury. She was taken to Scone Hospital from whence she was transferred to John Hunter Hospital within the hour.

8. Ms Waters was still unconscious at that point. An intracranial pressure monitor was inserted and she was retained in hospital for approximately two weeks before being discharged to a rehabilitation hospital, from whence she was transferred to the Brain Injury Rehabilitation Hospital where she remained for about two months.

9. The AMS found that Ms Waters had suffered a combined table value of 22% WPI.

PRELIMINARY REVIEW

10. 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.

11. The appellant employer requested that the worker be re-examined by a Panel AMS. As the legal member of the Panel found that a demonstrable error has occurred in relation to the contested issue, a re-examination was organised with Ms Waters and Dr Lahz of the Panel.

ORAL HEARING

12. The appellant employer submitted that an oral hearing should be heard "having regard to the difficulty that arises regarding the allocation of an appropriate class of impairment rating and also the selection of a level of impairment within a range in those circumstances".

13. The respondent resisted the application, submitting that no reasons were given other than it was the appellant employer's preference.

Decision

14. The Panel rejects the application for an oral hearing. The issues raised in this appeal are neither complex nor novel. The allocation of an appropriate class of impairment rating, and the selection of a level of impairment within that category, is a task that Medical Appeal Panels are often called on to perform. The written submissions have adequately engaged with these issues.

EVIDENCE

Documentary 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.

Medical Assessment Certificate

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.

FINDINGS AND REASONS

18. 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.

19. The issues raised in the appeal were somewhat general. The appellant employer submitted that there was either no evidence, insufficient evidence or inconsistent evidence that was the cause of the alleged errors. Two errors were alleged: the assessment of gait and station, and the assessment of mental impairment.

Gait and station

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

> "There are continuing right sided symptoms. [Ms Waters] is unable to run and has some difficulty walking on rough ground because of lack of her normal right leg function. …."

21. In discussing his findings on examination the AMS said [2]:

> "In the circumstances of the examination *in the office* there was no impairment of gait." (Emphasis added).

22. Dr Ron Granot, Neurologist, in his report to the appellant respondent of 15 May 2019, noted under "Current Status":

> "[Ms Waters] is riding her own horse, whom she grooms, feeds, rides (she is not able to ride as before - she feels her right side is weaker and less coordinated)."

23. Dr Granot did not consider the question of gait and station in his assessment.

24. Dr O'Sullivan, the Neurologist retained for Ms Waters, reported on 3 January 2019. He said that Ms Waters' right arm and leg were:

> "…still not 100% ….. Also she finds when riding [her] horse the right leg doesn't function as well. The right leg becomes tired when she does a lot of walking." [3]

25. In her statement of 25 September 2018, Ms Waters said in listing her disabilities:[4]

> "• I still have weakness in the right side of my body which mainly affects my right leg
>
> • The left side of my body works well and I can control my horse normally with that side of my body but my right side is slower and weaker and not as effective in controlling my horse. I notice that I drag my right leg when I am tired."

Submissions

26. The appellant employer submitted that the AMS had made a demonstrable error when he certified 5% WPI in the Table 2 Medical Certificate for "gait and station". The appellant employer contended that the AMS had made "a specific finding" when he allegedly said:

> "In the circumstances of the examination there is no impairment of gait".

Discussion

27. As can be seen, the AMS was misquoted by the appellant employer, which omitted the words "in the office," which we emphasised above.

28. We agree that within the confines of the office of the AMS, no impairment of gait of the nature described by Ms Waters, and described by Dr O'Sullivan, would be apparent. We do not read the AMS' comment as being a finding that gait and station had not been affected by Ms Waters' injury.

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[1] Appeal Papers page 21.
[2] Appeal Papers page 22.
[3] Appeal Papers page 132.
[4] Appeal papers page 42.

29. The fact that the AMS has allowed a 5% WPI in that regard is consistent with the finding by Dr O'Sullivan on 3 January 2019[5]. It is clear that the AMS accepted Ms Waters' description of her symptoms. Ms Waters is unable to run and has some difficulty walking on rough ground because her right leg function is not normal. Within the confines of his office, it is understandable that Dr Mellick was unable to observe such abnormalities of gait. However, it is clear that the assessment was made on an acceptance of Ms Waters' description, about which there is no reason to doubt.

30. This ground is accordingly rejected.

Incorrect criteria re gait and station

31. In his assessment of WPI in his Table 2 certificate,[6] the AMS indicated that he had applied Chapter 5 of the Guides[7] which in turn applied the provisions of Chapter 13 of AMA 5[8].

32. The assessments themselves were made pursuant to Tables in Chapter 13 and Chapter 15 of AMA 5. With regard to the assessment of gait and station, the AMS employed Table 15-6(c) and awarded 5%. Similarly with regard to the dominant upper extremity the AMS also utilised Table 15-6(a) of Chapter 15 to award a 5% WPI, although no appeal was made in that regard. Chapter 15 is entitled "The Spine." Chapter 13 is entitled "The Central and Peripheral Nervous System."

33. The appellant employer submitted that the assessment regarding station and gait had been made "by reference to the chapter applicable to the impairment of the spine".

34. Error had been made, it was submitted, because the AMS was asked to assess traumatic brain injury only.

Discussion

35. This submission must be rejected, for two reasons. Firstly, in the text to Table 15-6 at Chapter 15.7, the following appears:[9]

> "For bilateral neurologic or cortico spinal tract damage, consultation with a spinal cord injury specialist and review of chapter 13, the Central and Peripheral Nervous System, is recommended…… *thus for impairment[s] involving loss of use of the lower extremities, use the section in table 15-6 pertaining to station and gait impairment*….."
>
> (Emphasis added).

36. Further, Chapter 13.5[10] states:

> "Problems maintaining balance and a stable gait developed from a CNS (Central Nervous System) or Peripheral Neurologic Impairment…. Impairment ratings for station and gait disorder are determined according to the effect on ambulation (see Table 13-15)".
>
> A severe traumatic brain injury as suffered by Ms Waters can give rise to a central nervous system impairment.

37. Secondly, in any event, Table 15-6c is a copy of Table 13-15 "Criteria for Rating Impairments Due To Station And Gait Disorders".

[5] Appeal Papers page 137.
[6] Appeal Papers page 26.
[7] At 31.
[8] AMA 5 at 305.
[9] AMA 5 page 395 at 396.
[10] AMA 5 page 336.

38. We are accordingly satisfied that the AMS made no error in this regard.

Mental state impairment

39. At paragraph 10c of the MAC[11] the AMS considered the reports of the medical-legal referees retained by each side - Dr Dudley O'Sullivan for Mrs Waters and Dr Ron Granot for the appellant employer. Both specialists are Neurologists. He noted that both specialists found there to be a 10% WPI with respect to the Clinical Dementia Rating (CDR) relating to mental status. The AMS said:

> "My findings are in agreement but not identical with my colleagues in relation to the assessment of mental status impairment. All three of us agree that mental status impairment lies in the upper range. I respectfully point out that the data available is not sufficiently mathematical to make a justifiable fractionation between 10% and 14% after establishing basic agreement that mental status impairment exists in the upper range of Class 1. I would regard the mental status impairment to be of considerable significance and do not identify in my colleagues' assessments justification to differentiate between 10% and 14% and accordingly respectfully disagree.
>
> On the basis of my more recent assessment, I must allow the possibility of some progression because of such processes as Wallerian degeneration, which may take time to produce downstream abnormalities affecting parts of the nervous system more distant from those specifically identified to have been injured. Wallerian degeneration may progress."

40. The appellant employer submitted that the AMS fell into error in so finding. It submitted that he had failed to adequately consider the report of Dr Granot, and it submitted further that the AMS had erred in arbitrarily increasing the assessment without adequately explaining his reasons.

Dr Granot

41. In his report of 15 May 2019 Dr Granot gave his assessment scores on all categories in Table 13-5.[12] He said:

> "According to Table 13-5 page 319 of AMA 5, I would rate [Ms Waters] as a CDR of 0.5, given memory (M), which is the primary subcategory upon which to base the CDR is consistent slight forgetfulness. Further ratings include: None for Orientation; Judgement and problem solving - slight impairment; Community affairs - slight impairment; Home and Hobbies- slight impairment; Personal Care - fully capable of self-care. This places her in class 1 Whole person impairment, which is at the higher end, so I would rate her 10%."

42. In his later report of 6 June 2019 Dr Granot said:

> "The main driver of the whole person assessment of cognitive injury is memory."

Submissions

43. The appellant employer conceded that the medico-legal referees from either side of the record made an identical rating in respect of this category of 10%.

[11] Appeal Papers page 24.
[12] Appeal Papers page 402.

44. It was submitted nonetheless that the AMS failed to have regard to a comment by Dr Granot in his report of 6 June 2019 that:

> "The results of psychometric testing could shift the assessment towards a normal score…."

Discussion

45. A number of observations need to be made about the appellant employer's submission

46. Firstly, it is clear that from his reference to both the reports of Dr Granot and Dr O'Sullivan that the AMS had regard to their views. The fact that the AMS did not refer to Dr Granot's second report of 6 June 2019, does not mean either that he failed to read it, or that he failed to have regard to its contents.

47. There is a presumption of regularity that the AMS would have read the material that had been referred to him.[13] An AMS is not required to comment on every opinion that is before him, particularly if it was not relevant to his opinion. This is the case in the comment in Dr Granot's second report of 6 June 2019. The extract upon which the appellant employer relies, was a paraphrase of Dr Granot's actual finding. Dr Granot actually said:[14]

> "The 'as expected' assessment of [Ms Waters] executive functions could shift the assessment of Judgement and Problem solving of the CDR category towards a normal score, but I feel this is likely still affected to an extent and would not change the overall CDR category, given the primary driver of this is memory, as previously outlined."

48. Secondly, Dr Granot did not move this category from "slight" to "normal" in any event, notwithstanding that he discussed the possibility. He did not do so because he felt that the category was "likely still affected to an extent".

49. Thirdly, as again Dr Granot pointed out, such a movement would not have affected the overall CDR category of Class 1 WPI, with which opinion we agree.

50. Fourthly, the appellant employer has been overly selective in its submission (as it was regarding station and gait). Its failure to reproduce the entirety of the passage upon which it was relying demonstrated a somewhat cavalier approach to its task. Read in its entirety, Dr Granot's opinion regarding Judgement and Problem Solving was not relevant to the assessment in any event.

ARBITRARY INCREASE IN WPI

Submissions

51. The appellant employer submitted further that error had been made when the AMS "arbitrarily" increased the impairment assessment for this category from 10% to 14%. The appellant employer submitted:

> "In the circumstances of the agreement between the specialists relied on by the parties and in circumstances where a beneficial assessment has been made favourable to the respondent worker, the Appellant says it is both a demonstrable error and the application of incorrect criteria to arbitrarily increase the impairment assessment from the 10% which was the subject of an agreement of 14%."

[13] *Bojko v ICM Property Service Pty Ltd* [2009] NSWCA 175; *Jones v The Registrar Workers Compensation Commission* [2010] NSWSC 481.
[14] Appeal papers page 405.

52. The appellant employer also submitted that the comments by the AMS as to "the possibility of some progression," amounted to speculation only. It was argued that the possibility of some progression was an impermissible aspect of his assessment process, because the process was concerned with the findings on examination. The AMS' comment was said to have been speculation as to the likelihood of future deterioration and was "clearly" not a matter that could be taken into account.

53. The respondent countered that the AMS had complied with the relevant guidelines. He had taken a consistent history, conducted an examination and considered the documentary evidence. Accordingly no error had been made, it was submitted.

Discussion

54. We assume that when the AMS said, "On the basis of my *more recent* assessment" (emphasis added), that he was referring to his assessment being more recent than those of either Dr O'Sullivan (3 January 2019 and 28 March 2019) or Dr Granot (15 May 2019). We assume further that he was allowing for some progression in Ms Waters' condition between the time she was assessed by the medico-legal specialists and his assessment (13 August 2019). His comment that the Wallerian degeneration may progress, we agree was a reference to the possibility of future degeneration.

55. The advent of a severe traumatic brain injury increases the risk of future development of clinical dementia, probably by effect of reducing neural reserve. Degenerative conditions such as Alzheimer's Disease, vascular dementia or Parkinson's Disease (for example) can superimpose their effects on those of the pre-existing traumatic brain injury, giving rise to future neurological deterioration.

56. We were uncertain as to whether the increase from 10% to 14% WPI by the AMS was based on future degeneration. It is not completely clear that when he says he "must allow the possibility of some progression" whether he was referring to progression until the date of his examination else progression at some point in the future, although we thought it possible that he was proferring it as one possible explanation or justification for his determining 14% WPI rather than the 10% WPI, which had been assessed by independent medical examiners (IMEs). (It is also entirely possible and plausible that his clinical judgement in relation to the CDR determination simply and reasonably differed from that of the IMEs - see below. In fact our own assessment following examination concurred with his CDR assessment). The AMS described progression as a "*possibility*" (emphasis added), and noted that this kind of process "took time" to progress. We think it unlikely that superimposed degenerative changes would have revealed themselves at the time of the assessment, and postulate that the statement by the AMS might have been a hedge against future deterioration. If so, the assessment infringed the provisions of Chapter 1.6a of the Guides, which provide:

> "1.6 The following is a basic summary of some key principles of permanent impairment assessments:
>
> a. Assessing permanent impairment involves clinical assessment of the claimant as they present on the day…"

57. The other reason given by the AMS for the 4% increase concerned a "justifiable fractionation." The AMS found that the available data was not sufficiently "mathematical" to distinguish between 10% and 14%. There is a considerable distinction between a finding of 10% and 14%, not only from the financial entitlement for the different percentage levels, but in the degree of impairment. Class 1 of Table 13-6 gives a range between 1% and 14%, depending on the seriousness of the condition. We acknowledge that the AMS stated that he regarded the mental status impairment to be of "considerable significance", but it appeared from his comments that the level of significance was indistinguishable between 10% and 14%.

58. 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.

59. More than one conclusion was open in this case, and the AMS was consequently required to explain why he preferred a different conclusion to that of both medico-legal referees. The explanation we find, with respect, is inadequate for the reasons we have just enumerated. We accordingly find that a demonstrable error has occurred, and asked Ms Waters to attend a re-examination on 10 February 2020 with Dr Lahz. Her report follows.

> **"REPORT OF MAP RE-EXAMINATION OF MISS SALLY WATERS BY AMS DR SOPHIA LAHZ ON 10/2/20**
>
> Miss Sally Waters attended at Parramatta for re-examination on 10/2/20, being accompanied by her mother Marilyn. Ms Waters who is aged 25, and right-handed provided most of the history with occasional contributions from her mother.
>
> Ms Waters required additional tutoring during her primary school years (until year 6) for possible attention deficit disorder. Her mother said that she has always been better 'visually' than 'verbally'. Her mother also said that Sally coped with her high school studies without particular assistance, the difficulties being more apparent in the primary school years.
>
> Ms Waters confirmed her involvement in the work accident on 31/3/16 when she fell from a horse at approximately 4pm. Her last memory is of getting on the horse and her next approximately 3-4 days later, awaking at the hospital to see her mother.
>
> At the time of the accident, Ms Waters had been employed as a stable hand with duties of cleaning, feeding and grooming horses. She has always liked horses and is an experienced rider.
>
> The ambulance took her to Scone immediately afterwards (at which stage she was unconscious) and from whence she was taken by helicopter to John Hunter Hospital at Newcastle.
>
> Ms Waters spent approximately one week at the John Hunter Hospital. A brain scan showed signs of bleeding and contusion. An intracranial pressure monitor was inserted to the right frontal region, and she spent 2-3 days in ICU for close observations. No other surgery for the traumatic brain injury was required. According to the hospital records, the duration of post-traumatic amnesia was 20 days as measured on the Westmead PTA scale.
>
> Her mother said that after awaking, Ms Waters was impulsive and attempting to walk despite being paralysed down the right side of her body. For several days, she required one-on-one nursing with a bed made up on the floor. Her mother assisted Ms Waters with all aspects of self-care during this period.
>
> Once she had started walking, Ms Waters was moved to Rankine Park Hospital for further rehabilitation, taking place over the subsequent 2-3 weeks. Her mother said that she had essentially to 'relearn' how to walk and generally take care of herself.
> On discharge, she went home to her parents' cattle property near Scone. She was by this stage ambulant albeit with reduced balance, and there was ongoing right-sided weakness and incoordination, albeit improving. She was also independent with self-care although needing guidance and repeated reminders for more complex day-to-day activities.

Ms Waters then undertook a four-week rehabilitation 'transitional living programme' at Bar Beach with the Brain Injury Service. She stayed inhouse from Monday to Friday receiving multidisciplinary input from the physiotherapist, occupational therapist, and speech pathologist, and returning to the family property on the weekends. The focus during this period was on more complicated tasks involving 'thinking stuff', memory and 'learning how to live again'. Ms Waters said that she needed more input for memory and thinking difficulties than 'speech' which she said was 'not too bad'.

Following conclusion of the abovementioned rehabilitation programme, she returned to the family property to continue rehabilitation closer to home, now in Muswellbrook where she participated in additional physiotherapy (to regain fitness, balance and strength) and psychological interventions due to low mood and frustration due to 'not being able to do the things she did before the accident'. She mentioned that one of the effects of the subject work accident has been substantial curtailment of her freedom. In addition, she said that she was earlier prone to marked fluctuations in mood which were troublesome on a daily basis.

Ms Waters resumed part-time work in August 2016 with the original employer (Thomas Elmes). She was given suitable duties with horses such as marking boxes, walking horses, swimming the horses and arranging horse feeds. However, she struggled at work due to pervasive fatigue with poor sleep, and the early mornings were particularly difficult. She also said that she was often 'confused' and plagued by self-doubt.

Her mother said too that there was a distressing incident in which a horse died whilst Ms Waters was taking it swimming (this involved walking along the side of a pool, whilst leading the horse up and down). Somehow, the horse hit its head and then drowned. Ms Waters said that she panicked and did not know what to do. At the time, she had been doing this task unsupervised and felt that she had been 'shoved in at the deep end'.

Ms Waters said too that before the accident, she had been working alone and was the only employee, whereas after the work accident, there were other employees who did not understand the difficulties she was experiencing due to traumatic brain injury. She had asked her co-workers to write in the work diary, to effectively 'give her something to follow' although no one did that, making it hard for her to work out what needed doing.

In the finish, her employer went bankrupt and she 'had to get out of there'.

For the next two months, Ms Waters went back to the family property where she could help out with chores and horse care, self-paced. However, Ms Waters was understandably depressed about the circumstances of being unemployed in which she found herself.

Around this time, Ms Waters completed a formal driving assessment and regained her driver's licence which had been suspended after the work accident.

In late December 2017, she found work (again with horses) involving 'yearling preparation' for sale, located at Denman. Her duties were to feed, walk and groom the horses. She said the job was 'OK' to begin with although the co-workers were from other cultural and linguistic backgrounds to which she was not accustomed, leading to 'clashes'. One problem was that she could often not understand what they were saying. She also felt overwhelmed by the workload, noting that her roster was a full-time one working 0700-1600 for 14 days, then having two days off.
Ms Waters tried talking to the new boss about her problems although by April 2017 she felt there was no option but to quit and has not done any paid work until very recently (now working in childcare, discussed later).

Ms Waters saw a psychologist about depression and was also referred to a psychiatrist Dr Patricia Jungfer, who devised a useful medication regime (Escitalopram and Melatonin) on which she remains. Ms Waters said that her mood and spirits are much more stable since being placed on the above medications. She experiences the occasional 'down' day only. She also said (and her mother agreed) that anxiety levels have significantly improved with the medication. She still attends regular reviews with Dr Jungfer and at the upcoming psychiatric appointment, her mother said that her antidepressant medication is likely to be changed in order to stem weight gain. (Ms Waters has gained approximately 20 kg since the work accident.)

Early on after the work accident, Ms Waters was very irritable and snappy although this is occurring less often now. She has not lost any friends due to the accident, and is still in regular contact with school friends who have actually provided her with considerable support. Bouts of irritability nowadays are mostly reserved for immediate family members, and usually precipitated by criticism e.g. about her manner of driving or else a perception that her brother is the family 'favourite'. There have been instances where Ms Waters has felt excluded from family decision-making, and then expressed anger about 'not being consulted'. Her mother said that mostly such episodes can be worked through. It is unclear whether Ms Waters' irritability has actually improved or alternatively those around her have simply learned how not to 'press her buttons'.

Ms Waters feels more at ease around girls than boys. She is presently single with formation of a romantic relationship not being a priority at moment.

There have never been any physical altercations and there have not been any brushes with the law since the work accident.

Her mother said that Ms Waters used to be 'happy-go-lucky' before the work accident although this is no longer the case. She has lost some confidence and there is chronic low self-esteem. Ms Waters explained that she worries about: 'what will the next five years be like…..I know I'm not normal because I have a brain injury. When I tell someone, that I've had a brain injury, they look at me twice and ask if I'm OK'. Her mother added that she and her husband provide their daughter with practical support so that 'others don't have to know too much' (about the brain injury).

Sleep patterns remain inconsistent. Some nights, she sleeps very well whereas on others, there are difficulties falling asleep. Some days, she feels restless, and knows that she will be unable to sleep. She could not say the specific reasons for insomnia although it possibly involves rumination on worries about the future. On such days, she takes Melatonin, on average once or twice per week. Melatonin generally enables a good night's sleep. Ms Waters suggested that since the work accident, her body clock is a bit 'out'.

Fatigue levels have improved with the passage of time although tiredness remains problematic. Occasionally, she still lies down during the daytime. Mornings and evenings are worse, with her best most energetic time being the middle of the day.

From July-December 2019, Ms Waters was completing a childcare course at TAFE (Certificate III). She said that she found studies 'very hard' and required specific help 'to better understand the assessments she had to do'. Every Monday, she met with a mentor/advisor for half an hour although she did not require any specific assistance in the classroom. She was able to successfully participate in a three-week work placement, working 0800-1600 and also driving one hour either to or from the workplace/home although she also found this very hard. She said that she often stayed with her aunt to help with the fatigue. Whilst she managed the work placement, she struggled because of the 'long days' before adding that given the significant difficulty she would never complete any further study.

Her mother noted that Ms Waters copes less well with deadlines, stress and being ‘under the pump’.

She has recently started casual childcare with 3-5-year-olds, 1-2 days per week, about half an hour from home. She has only been in the role for a few weeks, and so far so good, although she prefers not to work consecutive days due to fatigue. Her ideal number of work days would be 2-3 days only per week, or else she said that she would be like a ‘zombie’.

She is still living with her parents on the property where her main responsibility is to care for seven horses (feeding, grooming, riding etc). She has been able to resume competitive ‘showing’ of horses since the work accident. She last competed (obtaining some awards) in late 2017 although she has not done so since due to the effects of drought. Her parents have been keen for her to resume riding for sake of fitness and enjoyment. Ms Waters still very much enjoys being around horses despite her work injury.

On the property, Ms Waters also makes limited contributions to cattle work such as mustering and with some indoor chores.

Apropos the right-sided weakness, Ms Waters reported that the right upper limb is mostly ‘fine’ although she notices mild ongoing weakness and reduced coordination at the hand. She notices this most of all whilst riding or else showing her horses.

Ms Waters is actually more concerned by ongoing weakness and reduced coordination affecting the right lower limb. She finds it difficult to walk quickly, walk long distances and cannot easily run. Negotiation of rough ground, inclines and steps is also more difficult. Again, she notices the right lower limb weakness particularly when riding.

Ms Waters has recently arranged a personal trainer and started attending the gym to further work on her fitness and stem weight gain. She has been using the treadmill and exercise bike. She has also been using dietary measures to lose weight, to date with little progress.

Aside from horse riding and horse care, Ms Waters does not have any specific hobbies.

Ms Waters is receiving regular payments from Racing NSW, and has little money to spare. She has few bills to pay, comprising only mobile phone and car repayments. Her mother generally reminds her to pay these bills. Her parents also assist her with any financial or administrative paperwork to ensure she has completed this satisfactorily. She worries that she will put down something ‘wrong’. She saves about half the remaining funds and spends the rest (although there is generally little left). Bed and board are fully covered by her parents.

Her short-term memory remains inefficient although she compensates for it quite effectively using mobile phone calendar and note functions.

Her mother said that Ms Waters lacks initiative and regularly needs a ‘push’ to do things.

She is an occasional smoker (social situations) and consumes little alcohol nowadays – one drink is quite enough due to the increased effects of alcohol since the accident.

Examination

On examination, Ms Waters was alert and fully oriented to time, place and person. She was neatly attired and well groomed, appropriate for the circumstances.

She is of solid and overweight build with weight 91 kg and height 167 cm.

She was aware of the purpose of the assessment.

She presented in a straightforward, genuine manner, occasionally seeking clarification of some questions.

Ms Waters could register 3/3 words although she could only spontaneously recall one word after five minutes. The other two words were only recalled, once she was given cues.

She had difficulty completing serial 7s from 100, initially producing 94, 86 and 71 and then requesting to start again, this time coming up with 94, 87, 80,73 and 66. She reported that mathematics is a long-term weakness.

Ms Waters could copy overlapping pentagons without difficulty.

She had no difficulty with the clock face drawing and could also set the hands to a specific time.

She could read, write and understand short sentences.

There were no apparent word finding problems during the interview.

Digit span was six forward and three backwards, which is reduced.

Ms Waters could give vague details about current news items such as ‘Chinese people arriving here sick’ and ‘bush fires’. She was also aware that the ‘royals’ had been in the news although she initially volunteered that ‘Camilla’ was leaving the royal family, recalling with a prompt, that it is actually Prince Harry.

Gait was normal and she could walk on tiptoe and heels without difficulty.

Romberg’s test was negative. There was mild swaying on the sharpened Romberg. Ms Waters could perform a tandem gait with light support from the examiner.

Olfaction was not formally assessed although no difficulties with sense of smell (or taste) were reported.

Eye movements were full in all directions and visual fields full to confrontation. Pupils were unremarkable.

There was no facial/jaw weakness and there was normal facial sensation.
No difficulties with hearing, tinnitus or dizziness were reported.

No difficulties with swallowing were reported.
Tongue movements were normal and there was central protrusion.
There was no pronator drift.

There was mild pyramidal weakness at the right hand compared with the left.

There was no measurable wasting at the arms (33 cm) or forearms (27 cm) at corresponding points.

There was normal right upper limb sensation.

There was mild slowing and clumsiness on finger nose testing and on rapid alternating (hand) movements, worse on the right side.

There was hyperreflexia affecting the right upper and lower limbs although plantar responses were flexor (normal).

There was normal right lower limb sensation.

There was no loss of power at the right lower limb although the heel shin testing was slow and clumsy on the right compared with the left.

There was no measurable wasting of the thighs (54 cm) or calves (39 cm) at corresponding points.

SOPHIA LAHZ
11 February 2020"

60. The Panel adopts the report of Dr Lahz. We are satisfied that Ms Waters satisfies the criteria for evaluation of traumatic brain injury, given verified abnormalities in GCS medically verified duration of PTA and significant intracranial pathology on CT scan or MRI.

61. Neuropsychological assessment in November 2018 by Dr Baird also confirmed difficulties with recall and word finding consistent with the effects of traumatic brain injury

62. AMA 5 Chapter 13 does not permit the combination of cerebral impairments, although these instructions are overridden by the instructions on page 31 of the Guides, which state that cerebral impairments should be evaluated and combined as follows, taking care to avoid duplication:

"
- Consciousness and awareness (no impairment in the worker's case)
- Mental status and cognition and highest integrative function (the worker has an impairment)
- Aphasia and communication disorders (no impairment evident at interview in the worker's case)
- Emotional and behavioural impairments."

63. Referring to CDR Table 13-5, page 320 AMA 5, we make the following assessments:

"Memory = 0.5 (there are memory problems for which Ms Waters compensates well with both electronic and paper diaries),

Orientation O=0 (fully oriented),

Judgment and problem solving JPS=0.5 (There is slight impairment in solving complex problems for which she receives practical assistance from her parents),
Community affairs CA=0.5 (she has struggled with work due to fatigue, difficulties coping under pressure, loss of confidence and higher-order cognitive difficulties secondary to traumatic brain injury),

home and hobbies HH=0.5 (there is slight impairment due to fatigue and reduced initiative) personal care PC=0 (fully capable of self-care)."

64. Applying the instructions on page 319 of AMA 5, the criteria are met for CDR=0.5 which gives an entitlement under Table 13-6 at page 320 to Class 1 mental status impairment, which we have discussed above. Class 1 provides for a range between 1-14% WPI.

65. Given the difficulties with fatigue, problem solving, and sustaining employment, we confirm that Ms Waters falls into the higher end of the latter range and agree with the 14% WPI assessed by the AMS. This is higher than the values ascribed by the experts on both sides of the record, as we discussed above. However, the Guides require us to assess a claimant as he/she presents on the date of assessment, as we observed earlier in these reasons, and we have explained how the higher assessment was reached by reference to Dr Lahz's detailed findings.

66. We also find that Ms Waters qualifies pursuant to Table 13-8[15], for impairment due to emotional or behavioural disorders. The Table gives four categories of WPI, depending on their severity. We are satisfied that the criteria are also met for Class 1, which also gives an entitlement of 0-14% WPI. Class 1 provides:

> "mild limitation of activities of daily living and daily social and interpersonal function."

67. As noted in Dr Lahz's report, Ms Waters suffers from difficulties with some interpersonal interactions with immediate family, and persons from culturally diverse backgrounds. However, whilst these symptoms are presently reasonably well controlled by antidepressant medication, she would very likely relapse if the antidepressant were withdrawn.

68. Chapter 1.32 of the Guides provides:[16]

> "Where the effective long-term treatment of an illness or injury results in apparent substantial or total elimination of the claimant's permanent impairment, but the claimant is likely to revert to the original degree of impairment if treatment is withdrawn, the Assessor may increase the percentage of WPI by 1%, 2% or 3%. This percentage should be combined with any other impairment percentage, using the Combined Values Chart."

69. In this case it would be reasonable to allow 3% WPI for this category, in lieu of providing an impairment rating by reference to Table 13-8 AMA 5. Her difficulties before the introduction of anti-depressants were substantial, which is why we choose 3% WPI within the permitted range of 1-3%.

70. The criteria are also met for an entitlement for station, gait and movement disorders as described in Chapter 13.5 of AMA.[17] Table 13-15 provides for four categories for rating impairment to station and gait. We are satisfied that Ms Waters meets Class 1, the criteria for which is:

> "Rises to standing position; walks, but has difficulties with elevators, grades, stairs, deep chairs and long distances."

71. Ms Waters has difficulty with long distances and elevations and we agree with the assessment by the AMS of 5% WPI in the available range between 1-9% WPI.

[15] AMA 5 page 325.
[16] Guides page 6.
[17] AMA 5 page 336.

72. We agree also with the rating given by the AMS of 5% pursuant to Table 13-16 of AMA 5.[18] This Table relates to impairment of one upper extremity, which in Ms Waters' case is her dominant right upper extremity. It provides also for a range of 1-9% WPI. There is mild difficulty with dexterity and strength during more challenging activities. The criteria are accordingly met for Class 1 (dominant extremity):

> "Individual can use the involved extremity for self-care, daily activities and holding, but has difficulty with digital dexterity."

73. If the above WPI values are combined pursuant to the Combined Values Chart[19] - i.e. 14, 5, 5 and 3, this provides an assessment of 24% WPI.

74. For these reasons, the Appeal Panel has determined that the MACs issued on 5 and 9 September 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*.

G De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar

[18] AMA 5 page 338.
[19] At AMA 5 page 604.

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **3371/19**
Applicant: **Thomas Elmes Racing**
Respondent: **Sally Waters**

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 WorkCover Guides	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)
Nervous System	31 March 2016	Chapter 5 Par 5.4, 5.9	Chapter 15 Tables 15-6(a) (dominant upper extremity- middle of the range)	5% (rounded)	0	5%
			Table 15-6 (c), gait & station, Class 1	5%	0	5%
			Chapter 13 Table 13-5 & 13-6	14%	0	14%
		Chapter 1.32	Table 13-8, page 325	3%	0	3%
Total % WPI (the Combined Table values of all sub-totals)					**24%**	

John Wynyard
Arbitrator

Dr Robin Fitzsimons
Approved Medical Specialist

Dr Sophia Lahz
Approved Medical Specialist

13 March 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*.

G De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar