WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-6243/19**
Appellant:	**Joseph Attard**
Respondent:	**Victor Bianchetti (deceased)**
Date of Decision:	**6 July 2020**
Citation:	**[2020] NSWWCCMA 121**

Appeal Panel:	
Arbitrator:	**Carolyn Rimmer**
Approved Medical Specialist:	**Dr Mark Burns**
Approved Medical Specialist:	**Dr John Garvey**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 9 April 2020, Joseph Attard (Mr Attard) 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, who issued a Medical Assessment Certificate (MAC) on 19 March 2020 and by Dr Henley Harrison, AMS, who issued an amended MAC on 9 April 2020. The appeal is against the MAC of Dr Mellick (the AMS) dated 19 March 2020 only.

2. The respondent is Victor Bianchetti, who is deceased (the respondent).

3. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - the assessment was made on the basis of incorrect criteria,
    - the MAC contains a demonstrable error.

4. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out. 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.

5. The Workers Compensation Medical Dispute Assessment Guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the Workers Compensation Medical Dispute Assessment Guidelines.

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

RELEVANT FACTUAL BACKGROUND

7. In these proceedings, Mr Attard is claiming lump sum compensation in respect of an injury, which occurred in the course of his employment on 16 October 2001, when he was hit by a branch falling from a tree.

8. An award was entered in the former Compensation Court of New South Wales (matter No 5565/02) against the respondent on 3 April 2003 in respect of injuries sustained on 16 October 2001.The Court made awards under s 66 as follows:

    (a) 100% permanent loss of hearing in the right ear;
    (b) 1.5% permanent loss of hearing in the left ear;
    (c) 30% permanent impairment of the neck;
    (d) 5% permanent impairment of the back;
    (e) 13% loss of use of the right leg at or above the knee;
    (f) 13% loss of use of the left leg at or above the knee;
    (g) 12.5% permanent loss of use of the sexual organs, and
    (h) 30% brain damage.

9. On 27 November 2019, Mr Attard lodged an Application to Resolve a Dispute in the Commission seeking further lump sum compensation in respect of the injuries sustained on 16 October 2001.

10. On 8 January 2020 Arbitrator Ross Bell issued a Certificate of Determination – Consent Orders remitting the matter to the Registrar for referral to Approved Medical Specialists (AMS) for assessment under the Table of Disabilities for injury sustained on 16 October 2001 as follows:

    (a) further permanent brain damage;
    (b) further permanent loss of hearing in the left ear;
    (c) further permanent impairment of the neck;
    (d) further permanent impairment of the back;
    (e) permanent loss of use of the right arm at or above the elbow;
    (f) permanent loss of use of the left arm at or above the elbow;
    (g) further permanent loss of use of the right leg at or above the knee;
    (h) further permanent loss of use of the left leg at or above the knee, and
    (i) further permanent loss of use of the sexual organs.

11. In a Referral for Assessment of Permanent Impairment to Approved Medical Specialist dated 17 January 2020, Dr Mellick was requested to assess permanent brain damage, permanent impairment of the neck, permanent impairment of the back, permanent loss of efficient use of the right and of the left arm at or above the elbow, permanent loss of efficient use of right and of the left leg at or above the knee and permanent loss of use of sexual organs. Dr Henley Harrison, AMS, was requested to assess the loss of hearing in the left ear.

12. On 19 March 2020, Dr Henley Harrison issued a MAC in respect of the appellant's permanent impairment in relation to injury to the left ear on 16 October 2001. That MAC was amended on 9 April 2020, and the assessment under the Table of Disabilities was revised to total 27.6% permanent impairment for hearing loss.

13. The AMS, Dr Mellick, examined Mr Attard on 25 February 2020. On 19 March 2020, Dr Mellick, AMS, issued a MAC in respect of the appellant's permanent impairment for injury sustained on 16 October 2001. Dr Mellick assessed the appellant's permanent impairment under the Table of Disabilities to comprise 40% in respect of brain damage, 40% in respect of the neck, and 0% in respect of the back, 0% in respect of loss of use of right arm at or above the elbow, 0% in respect of loss of use of the left arm at or above the elbow, 0% in respect of loss of use of right leg at or above the knee, 0% in respect of loss of use of the left leg at or above the knee, and 0% in respect of loss of use of sexual organs.

PRELIMINARY REVIEW

14. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Workers compensation medical dispute assessment guidelines.

15. The appellant did not request that Mr Attard be re-examined by an AMS, who is a member of the Appeal Panel.

16. As a result of that preliminary review, the Appeal Panel determined that there was an error in the MAC and it was necessary for Mr Attard to undergo a further medical examination because there was insufficient evidence on which to make a determination.

EVIDENCE

Documentary evidence

17. 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.

Further medical examination

18. Dr Mark Burns of the Appeal Panel conducted an examination of Mr Attard on 29 June 2020 by telephone and reported to the Appeal Panel.

Medical Assessment Certificate

19. 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

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

21. Mr Attard's submissions include the following:

    (a) The awards made by the Compensation Court of NSW on 3 April 2003 represent the minimum loss and permanent impairment that Mr Attard is entitled to noting that the totality of the medical evidence indicates that Mr Attard's condition has worsened in the intervening years.

    (b) The AMS did not give sufficient weight to the percentages found in the Short Minutes of Order dated 3 April 2003.

    (c) In respect of permanent impairment of the back, Mr Attard was awarded $3,000 in respect of 5% permanent impairment of the back in the proceedings in 2003. Dr Teychenne assessed current impairment as 5% of the back, Dr Hopcroft assessed 15% permanent impairment of the back. Dr O'Sullivan accepted that Mr Attard had a further 10% impairment of the back.

    (d) In the MAC, the AMS noted a limitation in straight leg raising to 70 degrees rather than the usual 90 degrees and noted from the x-ray and CT scans dated 25 September 2007 that there was a spinal fusion from C6 to T1.

    (e) The evidence on the examination from the doctors for both parties was that there was a further permanent impairment in the lumbar spine of 10% and compensation should be awarded accordingly.

(f) In respect of the loss of use of the left and right arms at or above the elbow, Mr Attard was awarded 30% permanent impairment of the neck in the proceedings in 2003. The AMS certified an additional 10% impairment of the neck, taking the total to 40% permanent impairment of the neck.

(g) Dr Teychenne and Dr Hopcroft both certified losses of use of the upper limbs in their reports.

(h) The AMS referred to Mr Attard's suffering of seizures post-injury with the last seizure occurring in 2017. The AMS noted that in the seizure Mr Attard suffered associated motor activity in all four limbs and indicated that the seizures have arisen because of the head injury. Whilst the epilepsy resulting in the seizures was post traumatic the AMS made no assessment for the loss of use of the limbs while that seizure activity took place. This must result in a loss of use of the upper limbs due to the involuntary movement that takes place during the seizures.

(i) Based on the long history of the seizure symptoms, some 16 years after the injury itself, this is a permanent condition. The fact that the seizures are partially controlled by Dilantin does not detract from the finding that the loss of use of the limbs during the seizure time, should be compensable under s 66 of the Act, as a permanent loss of use of the limbs, notwithstanding that the experiencing of those seizures is sporadic.

(j) The AMS noted that Mr Attard had a fusion from C6 to T1 on 19 May 2005. The AMS indicated that there are sensory symptoms involving the upper and lower extremities. Regardless of whether there is radiculopathy, this in itself should signify a permanent loss of use of the upper extremities due to the sensory symptoms.

(k) Dr Hopcroft noted that Mr Attard was developing increasing paraesthesia in both arms down to his hands and numbness and assessed 10% permanent loss of efficient use of both the right and left arms at or above the elbow. Dr Teychenne assessed 30% permanent loss of efficient use of both the right and left arms at or above the elbow.

(l) The loss of the use of the upper limbs from firstly the severity of the neck condition and secondly, from the loss of use of the limbs arising from seizures is a similar factual situation to what was decided by the Compensation Court in *Scrimshaw v SAR Wood Pty Limited* (1997) 14 NSWCCR 335 (*Scrimshaw*). In that decision, it was held that a worker who had suffered permanent impairment of the heart muscle in compensable circumstances, was entitled to permanent loss under s 66 for the loss of use of his limbs. The damage to the heart muscle impeded flow of the blood to the limbs causing fatigue if the worker used his limbs. This made the worker fit for light duties and the worker was awarded compensation for 10% permanent loss of efficient use of each of the limbs. Mr Attard through the suffering of seizures, has suffered a permanent loss of use of his upper limbs as a result of the seizures secondary to the brain injury received during the course of employment.

(m) Mr Attard stated that he has numbness periodically down his left and right arms and some numbness in his hands. There is sufficient medical evidence to show there is a permanent loss of use of the left and right arms at or above the elbow when coupled with the other sensory loss and involuntary movements that take place whilst Mr Attard is suffering seizures.

(n) In respect of the loss of use of the left and right legs at or above the knees, Mr Attard was awarded 13% permanent loss of use of the left and right legs at or above the knee in the proceedings in 2003. The AMS found there was no percentage loss of use of either leg at or above the knee.

(o) The appellant relied on the submissions made with regard to the upper limbs in respect of loss of use of the left and right legs, arguing that Mr Attard will suffer a permanent loss of use of the limbs in future seizures. These seizures, although rare, will result in a permanent loss of efficient use of the lower limbs during that period of time when the seizures take place, albeit rarely. While medication in the form of Dilantin will permanently remove the symptoms of the seizures, the fact remains that Mr Attard will be troubled with respect to seizure activity in the future if the medication is ceased.

(p) The AMS also noted "symptoms including numbness in both feet more marked on the right side provoked by sitting and improved by walking." The AMS found on examination straight leg raising was reduced to 70 degrees bilaterally (normally is 90 degrees). Yet after making those observations, the AMS indicated that "There is no abnormal sign on physical examination involving the upper extremities or the lower extremities." From his findings on examination and the history given, that Mr Attard does have a loss of use of the lower limbs, based on the involuntary movement experienced through seizures and through problems from his lower back. The AMS accepted that the seizures were caused by the brain injury and that there are sensory symptoms in the lower extremities.

(q) Dr Teychenne and Dr Hopcroft both made assessments of the loss of use of the right and left legs at or above the knee, above the previous award entered in the Compensation Court.

(r) Through Mr Attard's suffering of seizures, he has a permanent loss of use of his lower limbs as a result of the seizures secondary to the brain injury received during the course of employment, which is accepted by the AMS as being caused by the traumatic injury.

(s) The appellant also relied on the reasoning of the Court in *Department of Public Works v Morrow* (1986) 5 NSWLR 166 (*Morrow*).

(t) When considering the loss from the involuntary movement in the seizures, and the loss of sensory symptoms in the leg which only came about since the injury and have been present for the last 19 years, this would indicate that the permanent loss of use of both lower limbs is attributable to the work related injury on 16 October 2001.

(u) In respect of the loss of sexual organs, Mr Attard was awarded 12.5 % in the proceedings in 2003.

(v) Mr Attard stated that he has become urinary incontinent and suffers sexual dysfunction. Mr Attard has suffered a worsening of his symptoms based on loss of sexual functioning.

(w) The assessment by the AMS of 0% loss of sexual function should be revoked and an assessment made that is consistent with the assessment provided by Dr Teychenne at 45% or Dr Hopcroft at 30%.

(x) The MAC should be revoked and the appropriate percentages provided by the Appeal Panel.

22. The respondent's submissions include the following:

(a) The AMS is not bound by the previous findings and awards entered by the Compensation Court in Matter No: 5565/02 dated 3 April 2003. Reference to the Short Minutes indicates the Award was entered by consent following agreement between the parties and was not a formal finding by an arbitrator or an AMS. Therefore, the agreed percentages do not truly reflect the degree of impairment Mr Attard suffered at that time.

(b) The respondent disputes that the totality of the medical evidence indicates that Mr Attard's medical condition has worsened over the intervening years.

(c) The AMS concluded on the basis of the MRI of the claimant's head performed in 2002 that the episodes of unconsciousness diagnosed as epilepsy should be regarded as post traumatic epilepsy arising from the injury in question and the contusion that occurred in the left temporal lobe in 2001.

(d) On physical examination, the AMs recorded:

(i) cervical movements asymmetrically restricted on rotation to the right and left with restriction also in flexion and extension;

(ii) no wasting of the paracervical or shoulder girdle muscles and no wasting or asymmetry of the upper extremities. No disorder of tone, coordination or sensation and the deep tendon reflexes were brisk and symmetrical;

(iii) fine finger movement was performed normally bilaterally;

(iv) ability to assume the seated position with hips flexed and knees extended and no apparent discomfort in that position;

(v) straight leg raising to 70 degrees bilaterally;

(vi) no wasting of the thigh or calf muscles and no abnormalities of contour, posture, tone, power production, coordination or of the superficial or deep modalities of sensation;

(vii) deep tendon reflexes were brisk and symmetrical and the plantar responses were flexor;

(viii) in the standing position, forward flexion and lateral flexion were limited without paravertebral muscle spasm. Movements were symmetrically reduced. Able to stand on tiptoes and his heels without difficulty;

(ix) no abnormality of gait. Carried a walking stick in his right hand but did not rely on it in any way during ambulation, and

(x) Rombergism was absent.

(e) The AMS found there was no abnormal sign on physical examination involving the upper extremities or the lower extremities and accordingly the symptoms reported were not associated with diagnostic evidence of any neurological consequence of the injury impairing motor or sensory function in the upper or lower extremities. There was no symptomology or findings on neurological examination pointing to impairment of sexual function because of the injury in question. Therefore, the AMS did not fall into error in failing to assess Mr Attard with any permanent impairment of the back, arms, legs or sexual organs.

(f) The AMS specifically states he did not identify any assessable abnormality of the lumbar spine. Although there were sensory symptoms involving the upper and lower extremities his clinical assessment identified no evidence of radiculopathy or evidence that would justify attributing the sensory symptoms in the extremities to a brain injury. He found no evidence of an assessable impairment of the right or left upper extremity at or above the elbow or the right or left leg at or above the knee.

(g) The AMS found no basis to attribute permanent impairment of the sexual organs to the injury in question noting there was no neurological evidence on examination indicating a neurological cause for impairment of sexual function. There was no abnormality of bladder or bowel sensation or function.

(h) In respect of permanent impairment of the back, the AMS specifically rejected the findings of Dr Hopcroft, Dr Robinson and Dr Teychenne and the complaints relayed to Dr O'Sullivan apart from the limitation in straight leg raising to 70 degrees. The AMS recorded no complaints of any problems in Mr Attard's back or legs. It was open to the AMS to find that there was no permanent impairment of Mr Attard's lumbar spine.

(i) In respect of permanent loss of use of the right and left arms at or above the elbow, the AMS found that Mr Attard suffered a loss of motor activity in all four limbs whilst undergoing seizures post injury, the last of which occurred in 2017.

(j) The AMS made it clear that the seizures are successfully treated with Dilantin and thus there is no permanent loss of use of the left and right arms at or above the elbow.

(k) The presence of pathology in the neck does not necessarily result in some radicular loss of use of both the right and left arms. While the AMS accepted there were sensory symptoms involving the upper and lower extremities he addressed those findings and stated that the findings would not justify attributing the sensory symptoms to a brain injury.

(l) Mr Attard made no complaint to the AMS of increasing paraesthesia in both arms down to his hands and numbness as reported by Dr Hopcroft. It cannot be assumed this is the same sensory loss that was referred to by the AMS.

(m) There is no similarity between the injury suffered by Mr Attard and his ongoing impairment such as that decided in the decision of *Scrimshaw*. In that case the Compensation Court found that the damage to the heart muscle impeded the flow of blood to the limbs causing fatigue if the worker used his limbs. Therefore, the condition was permanent whereas in this case the loss of use of the appellant's upper limbs as a result of the seizures is only transient and is controlled by use of medication.

(n) In respect of permanent loss of use of the right and left legs at or above the knee the respondent relies on the submissions with regard to the upper limbs above and disputes that there is any permanent loss of use of the right and left legs at or above the knee as a consequence of unconsciousness associated with motor activity in all four limbs.

(o) In respect of permanent loss of use of sexual organs, the AMS specifically found there was no abnormality of the appellant's bladder or bowel sensation or function and Mr Attard made no complaint to the AMS of abnormality of bladder or bowel sensation or function. There was no specialist medical evidence to support the claim that he has become urinary incontinent.

(p) The respondent notes the decision of Neilson J in *Malcolm v Roads and Traffic Authority* (1995) NSWCCR 252 (*Malcolm)* which was approved by the Court of Appeal. However, the respondent disputes that there has been any worsening of symptoms based on loss of sexual functioning since the agreement between the parties in 2003.

(q) The AMS provided reasons as to why he did not accept that the permanent impairment of the sexual organs was not attributable to the work injury findings that there is no neurological evidence to indicate a neurological cause for impairment of sexual function.

(r) The AMS is not obliged to accept the medical opinion of other specialists (*State of NSW v Kaur* [2016] NSWSC 346).

(s) The MAC should be confirmed.

FINDINGS AND REASONS

23. 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.

24. 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.

25. The role of the Medical Appeal Panel was considered by the Court of Appeal in the case of *Siddik v WorkCover Authority of NSW* [2008] NSWCA 116 (*Siddik*). The Court held that while prima facie the Appeal Panel is confined to the grounds the Registrar has let through the gateway, it can consider other grounds capable of coming within one or other of the s 327(3) heads, if it gives the parties an opportunity to be heard. An appeal by way of review may, depending upon the circumstances, involve either a hearing de novo or a rehearing. Such a flexible model assists the objectives of the legislation.

26. Section 327(2) was amended with the effect that while the appeal was to be by way of review, all appeals as at 1 February 2011 were limited to the ground(s) upon which the appeal was made. In *New South Wales Police Force v Registrar of the Workers Compensation Commission of New South Wales* [2013] SC 1792 Davies J considered that the form of the words used in s 328(2) of the 1998 Act being, 'the grounds of appeal on which the appeal is made' was intended to mean that the appeal is confined to those particular demonstrable errors identified by a party in its submissions.

27. In this matter, the Registrar has determined that he is satisfied that at least one of the grounds of appeal under s 327(3)(d) is made out, in relation to the AMS's assessment of Mr Attard's permanent impairment.

28. The Appeal Panel reviewed the history recorded by the AMS, his findings on examination, and the reasons for his conclusions as well as the evidence referred to above.

29. The Appeal Panel did not accept the appellant's submission that the AMS was bound by the previous findings and awards entered by the Compensation Court in Matter No: 5565/02 dated 3 April 2003. That Award was entered by consent following agreement between the parties and was not a formal finding by a judge and the agreed percentages may not truly reflect the degree of impairment Mr Attard suffered at that time. The Appeal Panel also considered that while the degree of impairment or disability in a particular body part may remain the same, there may be a deterioration or an improvement in the level of disability over time.

Assessment of the Back

30. The appellant submitted that the AMS erred in assessing 0% permanent impairment of the back. The evidence on the examination from the doctors for both parties was that there was a further permanent impairment in the lumbar spine of 10% and compensation should be awarded accordingly.

31. The AMS at 5 of the MAC under "Findings on Physical Examination" wrote:

> "He was able to assume the seated position with hips flexed and knees extended and appeared in no discomfort in that position. Straight leg raising was performed to 70° bilaterally without contact from the examiner.
>
> There was no wasting of the thigh or calf muscles and no abnormalities of contour, posture, tone, power production, coordination or of the superficial or deep modalities of sensation. The deep tendon reflexes were brisk and symmetrical and the plantar responses were flexor.
>
> In the standing position, forward flexion and lateral flexion were limited without paravertebral muscle spasm. Movements were symmetrically reduced. He was able to stand on tiptoes and on his heels without difficulty."

32. The AMS at Part 6 of the MAC noted that a cervical spine scan performed on 19 May 2005 was reported to reveal an anterior spinal fusion from C6 to T1.

33. The AMS at 10c of the MAC wrote:

> "I do not identify assessable abnormality of the lumbar spine and I disagree with Dr Teychenne's assessment in that regard. I am in agreement with Dr O'Sullivan's assessment."

34. The Appeal Panel reviewed the evidence in the matter.

35. Dr Hopcroft, in a report dated 23 November 2016, assessed 15% permanent impairment of the back.

36. In his earlier report dated 6 July 2016, Dr Hopcroft noted that Mr Attard had ongoing and significant thoracic spine pain and lumbosacral pain and was noticing the development of paraesthesia and numbness of both feet. He wrote: “It is quite likely that the serious axial compression force of the tree branch falling on his head is finally producing long term post traumatic spondylitic changes in his lumbar spine also”. On examination, Dr Hopcroft noted that Mr Attard had pain down his thoracic spine with a slight thoracic kyphotic curve developing and tenderness over the lumbar spine but no discernible radicular deficit in the lower limbs.

37. Dr Teychenne, in his report dated 8 July 2019, noted that Mr Attard complained of pain in the low back, which had been present sine the injury. He assessed current impairment as 5% impairment of the back of the back in comparison to a most extreme case.

38. Dr O’Sullivan, in his report dated 10 October 2019, noted that Mr Attard complained of pain in the lower back and examination of the lumbar spine revealed some paravertebral muscle spasm and some restriction of movement. Dr O’Sullivan wrote:

> “Using the Table of Maims I consider he has a 50% permanent impairment of his neck and of the most extreme case. I consider that he has a 10% further impairment with regards to his lumbar spine.”

39. The evidence from Dr Hopcroft and Dr O’Sullivan was that there was a further permanent impairment in the back. The AMS stated that he agreed with Dr O’Sullivan’s assessment of the lumbar spine. However, Dr O’Sullivan assessed a 10% further impairment of the lumbar spine, while the AMS assessed 0% impairment of the back. The Appeal Panel was satisfied that the AMS erred in stating that he agreed with the assessment of Dr Sullivan when in fact the AMS assessed 0% permanent impairment of the back as a result of the injury on 16 October 2001.

40. The Appeal Panel noted that the AMS on examination reported a limitation in straight leg raising to 70 degrees rather than the usual 90 degrees, a reduced range of flexion forwards and laterally. There was a history of significant back pain following the injury. The AMS did not report in any detail as to how back pain affected the level of function. The Appeal Panel was satisfied that there was some disability in the back and the AMS erred in making an assessment of 0% permanent impairment of the back.

41. The Appeal Panel considered that in regard to an assessment of permanent impairment and permanent loss for injuries received before 1 January 2002 the authorities were clear that “loss of efficient use” of a thing was not concerned only with objective signs or the physiological restrictions of movement, but with “use”. In this sense the method of assessment under Table of Disabilities was significantly different from the method of assessment under AMA 5 or the Guidelines. The law in this regard was well stated in the decision of *Cummins v G James Safety Glass Pty Ltd* (1994) 10 NSWCCR 688, in which Burke J stated at page 3 that the Guides (AMA 5) are “devoted to assessment of ‘impairment’ which may or may not, in the context, be synonymous with the concept of permanent loss of efficient use”. Burke J observed that the “concept of permanent loss of efficient use is not concerned, at least not solely, with the physiological or anatomical restrictions of movement. It is a much wider concept. It is concerned with ‘use’...”. While the method of assessment under the Table of Disabilities should be as objective as possible, it was clear that an assessment of the “loss of efficient use of” a part of the body must also address subjective considerations. These included the worker’s account of the day-to-day function of that part of the body, the level of efficiency of that part, and whether that part of the body is operating as it should and doing so competently and well.

42. The appellant relied on the reasoning of the Court of Appeal in *Morrow.* In *Morrow* the Court of Appeal held that a reduced loss of a limb directly caused by pain in another part of the body constitutes a "loss of efficient use" of a limb within the meaning of the *Workers Compensation Act 1926*, s 16(5). In *Morrow*, the evidence was that the use of the worker's arms and limbs caused pain to his back and he refrained from making use of his limbs because it would cause pain. McHugh JA held that this constituted loss of the efficient use of the "arms and limbs".

43. The Appeal Panel considered that the AMS erred in failing to address subjective considerations in making his assessment under the Table of Disabilities of the back, both arm and legs. The AMS looked at neurological deficit in the upper and lower extremities (which was impairment) but not loss of efficient use (which was a disability). The presence of a disability without impairment often occurs when pain or stiffness alters function but not enough to give a WPI score.

44. The Appeal Panel considered that MAC and various medical reports relied upon by the parties did not include a sufficiently detailed history concerning Mr Attard's day-to-day function of the back, arms and legs and how pain affected the level of function. In view of the lack of a detailed history, the Appeal Panel determined that Mr Attard should be re-examined by telephone so that a proper history could be obtained concerning the level of function in the back, arms and legs.

45. The Appeal Panel decided that it was necessary to re-examine as there was insufficient evidence on which to make a determination.

46. As noted above, Dr Burns re-examined Mr Attard on 29 June 2020 by telephone. Dr Burns provided the following report.

> **"1. The workers medical history, where it differs from previous records**
> Mr Attard joined the telephone conference unaccompanied. He explained that his wife had obtained some casual work this morning and thus was unable to be present.
>
> I discussed the history reported by Dr Mellick (AMS) in his report dated 19 March 2020. He was relatively vague about Dr Mellick's assessment but confirmed that the history was correct.
>
> **2. Additional history since the original Medical Assessment Certificate was performed**
> A detailed further history was obtained from Mr Attard. He reported no change in his medical condition since the appointment with Dr Mellick. He then stated that his medical condition has been relatively stable since soon after he developed epilepsy in 2002.
>
> ***Current Symptoms:***
> Cervical spine: He reported intermittent pain in his neck which could be unilateral or bilateral. The pain occurred once or twice per fortnight, sometimes with a headache. He stated that the neck was always stiff but not always painful. The pain would resolve over 15 – 20 minutes with activity. He rated the pain as 3/10 without the headache and 6/10 with the headache. Associated with the headache were pins and needles in the palmar aspect of all fingers. He was uncertain if the thumbs were involved.
>
> Arms: Apart from the pins and needles mentioned above he reported no other symptoms into either arm. He did not report weakness in either arm.

Back: He reported an occasional burning pain in the midline of his upper back between the shoulder blades. He rated this pain as 3/10 and it also improved over 10 – 15 minutes when standing and walking.

He did not report any pain in his lower back but did report intermittent numbness in the soles of his feet. He described this as like standing on needles. This occurred once or twice every fortnight. He stated that since recommencing weekly physiotherapy his pains (and his mobility) have all improved.

Legs: He reported no pain or discomfort in either leg. He does though feel unsteady on his feet and uses a walking stick constantly when he goes out. He occasionally uses it at home. He has 3 walking sticks so that one is always at hand. On questioning he stated that his unsteadiness was more due to balance problems and not weakness.

Current Treatment:
He attends Dr David Snedden, his GP at least monthly. He is attending physiotherapy once per week for treatment of his neck and back. He believes that the treatment and exercises give him about 3 days improvement in his flexibility, mobility and pain levels. He would like the insurer to approve this treatment for twice per week.

His current medications include;

- Dilantin – for epilepsy
- Rosuzet (Ezetimibe & Rosuvastatin) – for high cholesterol
- Noten (Atenolol) – for hypertension
- Amitriptyline – an antidepressant
- APO-Duloxetine – an antidepressant and
- Aspirin

Functional Capacity:
Domestic Activities: Mr Attard and his wife live in a wooden pole house which was built for them in 1994. The house is on a sloping block of land with a garage, workshop and laundry under the 2 storey home. The first storey consists of 2 bedrooms, a separate lounge and dining room, a bathroom and kitchen. The second storey also contains 2 bedrooms but is uncompleted.

The 3 acre block of land is mostly sloping and timbered. There is though a small flat area in front of the house and a small vegetable garden behind the house. He reports that they also keep chickens.

With respect to cleaning he has a long handled static mop which he uses on the timber and tile floors. He used to use the vacuum cleaner as well but increasing back and neck discomfort has led him to giving this away. He can do the washing and hang it out one piece at a time (if the line is tight as this aids his balance).

His wife does the majority of the shopping but he can do small amounts if she is not available.

He does the majority of cooking because he likes to cook and has done so since taught by his mother.

Outdoor Activities: He stated that he has ceased most outdoor tasks including using the lawn mower, whipper snipper and hedge trimmer due to his balance problems and to a lesser extent his neck and back pain. Also with the hedge trimmer he reported some weakness in his arms during use. He does collect the eggs from the chickens.

Mobility: Mr Attard has a 40kg cattle dog cross which he walks on a daily basis. They walk 1km to the main road and 1km back. This is on a flat bitumen surface and takes 45 – 60 minutes depending upon the weather and how he feels. He states that he uses his walking stick to help with balance during the walk.

He was initially suspended from driving after his epilepsy was diagnosed. After his epilepsy was stabilized he recommenced driving and continues to do so. He regularly drives to his local town which takes 15 minutes. He can also drive to Tweed Heads to see his Psychiatrist (20 – 30 minutes). Longer driving is more tiring and he normally does this in tandem with his wife. The most that he can drive at one time is 3 hours in a day. He reported that he then has increasing balance problems and stiffness in his neck and back.

He requires a yearly driving medical assessment for both his epilepsy and his heart condition.

Hobbies: He stated that he has made rustic chairs out of branches in his garage. It appears that this is infrequent as he has only completed 3 chairs in the last 10 years.

In the past he played golf but after his accident could not continue due to balance problems during his swing. He tended to fall over. He could not remember when he stopped playing but stated that it was many years ago. He was regularly (weekly) playing lawn bowls but this ceased due to COVID 19. He is looking forward to returning to this activity. When playing he uses a cane with a large flat bottom to help with his balance. It also helped with bending which he found difficult. He tends to squat bending his knees.

Occupational Activities: He has not returned to work since his work injury.

Sexual Activities: He confirmed that his sexual activities have diminished since his injury but have not altered recently. He reported having infrequent attempts at sexual intercourse and rarely sustaining an erection.

3. Findings on clinical examination
As the examination was carried out by telephone no physical examination was possible.

4. Results of any additional investigations since the original Medical Assessment Certificate
No further investigations have been carried out."

47. The Appeal Panel has adopted the report and findings of Dr Burns.

48. In respect of the back, the Appeal Panel noted that Mr Attard gets back pain and stiffness which impacts on his bending and certain activities such as playing golf, lawn bowels and gardening. Mr Attard can however do most activities at a slower pace and with some modifications. The Appeal Panel accepted the AMS's findings that there was no objective evidence of radiculopathy. The Appeal Panel considered that since 2003 (the date of the last assessment) there has been a minor deterioration and assessed 10% permanent impairment of the back.

49. In respect of the left and right arms at or above the elbow, the Appeal Panel agreed with the AMS that there was no evidence of radiculopathy in either arm. In the re-examination by Dr Burns, Mr Attard reported mostly stiffness in the neck with only occasional pain. In respect of the arms, Mr Attard did have some pins and needles in the hands occasionally but these appear to have little, if any impact, on his activities. Mr Attard could walk with a dog leash in one hand and a walking stick in the other for 2 km without reported arm symptoms. The Appeal Panel considered that the major disability was the neck and there was very little disability relating to his arms. Mr Attard's history certainly did not support Dr Teychenne's diagnosis of incomplete spinal cord injury. The Appeal Panel, after taking into account the reported symptoms and difficulty with a hedge trimmer, made an assessment of 5% loss of efficient use of the left arm at or above the elbow and 5% loss of efficient use of the right arm at or above the elbow.

50. In respect of the left and right legs at or above the knee, the Appeal Panel noted that the AMS found no evidence of radiculopathy in either leg. However, Mr Attard did have back pain which could radiate into the legs, especially after bending. Mr Attard also reported numbness in the soles of the feet which could be neuropathic in nature. In the re-examination by Dr Burns, Mr Attard stated that in order to overcome his back stiffness when playing bowls, he had learnt to bend his knees and squat. Mr Attard also stated that his legs have not changed over time. The Appeal Panel concluded that there has not been any assessable increase in loss of efficient use of either leg beyond 13% since his assessment in 2003. The Appeal Panel assessed 13% permanent loss of efficient use of the left leg at or above the knee and 13% permanent loss of efficient use of the right leg at or above the knee.

Permanent loss of use of upper limbs and lower limbs as a result of the seizures

51. The appellant argued there was a loss of use in both arms and both legs arising from seizures suffered by Mr Attard. The appellant referred to the decision of *Scrimshaw* and that Mr Attard through the suffering of seizures, had suffered a permanent loss of use of his upper limbs and lower limbs as a result of the seizures secondary to the brain injury received during the course of employment.

52. The AMS at page 2 under "History relating to injury" wrote:

> "Approximately four months after the injury in question he had an episode of lost consciousness associated with motor activity. He was seen by a neurologist, Dr Corbett, and anticonvulsant medication was prescribed at that time. Other episodes of unconsciousness occurred associated with motor activity in all four limbs, the last such episode having occurred in 2017. Neurological supervision of high quality has been provided and the need for anticonvulsant medication continues. It is noted that an MRI scan of the head was performed in 2002 which revealed changes indicative of a left sided cerebral contusion at some time in the past. On the basis of the history provided above and the absence of any past injury or seizures, it is likely that the MRI abnormality arose because of the head injury in question. No other reasonable explanation is available. It follows, therefore, that the episodes of unconsciousness diagnosed as epilepsy should be regarded to be post-traumatic epilepsy arising because of the injury in question and the contusion that occurred in the left temporal lobe in 2001."

53. The AMS in the MAC on page 4 under "Summary of injuries and diagnoses" wrote:

> "Mr Attard was symptomless prior to the injury in question. The injury was associated with evidence of a cervical spine fracture requiring a fusion procedure. There was MRI evidence of a temporal lobe contusion with a subsequent history of episodes of unconsciousness diagnosed as tonic clonic convulsions, for which he was placed on anticonvulsant medication, which is continuing.

> There is no abnormal sign on physical examination involving the upper extremities or the lower extremities and accordingly the symptoms reported above are not associated with diagnostic evidence of any neurological consequence of the injury impairing motor or sensory function in the upper or lower extremities. There is also no symptomatology or findings on neurological examination pointing to impairment of sexual function because of the injury in question."

54. Under "Reasons for Assessment" the AMS wrote:

> "There is history that seizures occurred in temporal proximity to the head injury. The seizures should be regarded to be consequential upon the underlying brain injury. Mr Attard is continuing on anticonvulsant medication. The seizures are consequential upon the brain injury and the assessment I make here incorporates acknowledgement of the seizures being consequential upon the injury in question."

55. The Appeal Panel noted that the AMS reported that the seizures were successfully treated with Dilantin and there had been no seizure since 2017.

56. In *Scrimshaw*, the Compensation Court found that the damage to the heart muscle impeded the flow of blood to the limbs causing fatigue if the worker used his limbs Therefore, the condition in *Scrimshaw* was permanent. In this case, the Appeal Panel was satisfied that the loss of use of Mr Attard's upper limbs or lower limbs as a result of the seizures was only transient, had not occurred for about three years and was controlled by use of medication.

57. The transient symptoms in the upper and lower limbs in a seizure have appeared intermittently and could not be considered to constitute or cause a permanent loss of efficient use of the upper or lower limbs. The mere possibility of further seizures in this case does not amount to any permanent impairment of function in the arms and legs. The infrequency with which seizures have previously occurred and the long period since the date of the last seizure do not support any conclusion in the present case that there is any permanent impairment of function in the arms and legs relating to the seizures.

Loss of sexual organs

58. The appellant noted that Mr Attard had stated that he suffered sexual dysfunction and a worsening of his symptoms. The appellant submitted that the assessment by the AMS of 0% loss of sexual function should be revoked and an assessment made that was consistent with the assessment provided by Dr Teychenne at 45% or Dr Hopcroft at 30%.

59. The Appeal Panel noted that in respect of the loss of sexual organs, Mr Attard was awarded 12.5 % in the proceedings in 2003.

60. The AMS in the MAC on page 3 wrote:

> "He also reported impairment of sexual function and cannot recall when he last experienced sexual intercourse or an erection. However, he does not report any abnormality of sensation in the region of the perineum, penis or scrotum and there is no reported abnormality of bladder or bowel sensation, function or control."

61. In his statement dated 25 November 2019, Mr Attard said he had urinary incontinence for 10 years, difficulty achieving and maintaining an erection and no feeling of ejaculation. Mr Attard said that he had an active sex life prior to 2001 and now had sexual intercourse four to five times a year, limited to a couple of minutes because of pain in back, neck and headaches.

62. Dr Hopcroft, in his report dated 6 July 2016, noted that Mr Attard had atherosclerosis since 2005, prostatic hypertrophy since 2014 and recurrent urinary tract infections. In a supplementary report dated 23 November 2016, Dr Hopcroft assessed 30% permanent loss of sexual organs due to the accident, back pain and resultant alcohol abuse.

63. Dr Teychenne, in his report dated 15 June 2019, noted that Mr Attard had urinary urgency over the last 10 years and could be incontinent and had two episodes of urinary incontinence over the past three months and urinary frequency. Dr Teychenne reported that Mr Attard's erections no longer lasted and he did not have any feeling of ejaculation and erections were about 75% of what they were prior to the injury. In a supplementary report dated 8 July 2019, Dr Teychenne assessed 45% for permanent loss of use of sexual organs.

64. Dr O'Sullivan, in a report dated 10 October 2019, noted that Mr Attard had no significant bladder or bowel difficulties apart from prostate problems. Dr O'Sullivan considered that there was no loss of sexual function (focal problem of prostatic hypertrophy) and assessed 0% for loss of sexual function.

65. The Appeal Panel noted that the AMS did not appear to consider whether pain from the back and neck interfered with sexual function. In *Malcolm*, Neilson J found that Mr Malcolm had a loss of efficient use of his penis as a sexual organ because of his inability to use it because of pain in his back. The Appeal Panel considered that the AMS erred in not considering whether Mr Attard had a loss of efficient use of his sexual organ because of his inability to use it because of pain in his back and neck.

66. The Appeal Panel agreed with the AMS that that there is no neurological evidence to indicate a neurological cause for impairment of sexual function. However, the Appeal Panel accepted that Mr Attard now has sexual intercourse four to five times a year, limited to a couple of minutes because of pain in back, neck and headaches.

67. The Appeal Panel considered that prostatism, which had developed in 2014 was also interfering in sexual function.

68. Accepting the history given to Dr Teychenne, the Appeal Panel concluded that Mr Attard has lost 25% of his sexual function. However, the Appeal Panel considered that a reduction should be made for prostatism and increasing effect of age and coronary artery disease on sexual function which had occurred since the injury in 2001. The Appeal Panel concluded that an assessment of 12.5% was appropriate in all the circumstances.

69. In conclusion, the Appeal Panel assessed 10% permanent impairment of the back, 5% permanent loss of use of the left arm at or above the elbow, 5% permanent loss of use of the right arm at or above the elbow, 13% permanent loss of efficient use of the left leg at or above the knee, 13% permanent loss of efficient use of the right leg at or above the knee and 12.5% permanent loss of use of sexual organs.

70. For these reasons, the Appeal Panel has determined that the MAC issued on 19 March 2020 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*.

T Ng

Tina Ng
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received before 1 January 2002

Matter Number: **6243/19**
Applicant: **Joseph Attard**
Respondent: **Victor Bianchetti (deceased)**

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:

Assessment in accordance with the Table of Disabilities for injuries received before 1 January 2002

Body Part (describe the body part as per Table of Disabilities) e.g. right leg at or above the knee	**Date of injury**	**Total amount of permanent % loss of efficient use or impairment**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Total permanent % loss of efficient use or impairment attributable to this injury** (after deduction of any pre-existing impairment in column 4.)
Permanent brain damage	16.10.01	40%	0%	40%
Permanent impairment of neck	16.10.01	40%	0%	40%
Permanent impairment of back	16.10.01	10%	0%	10%
Permanent loss of efficient use of right arm at or above the elbow	16.10.01	5%	0%	5%
Permanent loss of efficient use of left arm at or above the elbow	16.10.01	5%	0%	5%

Permanent loss of efficient use of the right leg at or above the knee	16.10.01	13%	0%	13%
Permanent loss of efficient use of the left leg at or above the knee	16.10.01	13%	0%	13%
Permanent loss of use of sexual organs	16.10.01	12.5%	0%	12.5%

Carolyn Rimmer
Arbitrator

Dr Mark Burns
Approved Medical Specialist

Dr John Garvey
Approved Medical Specialist

6 July 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*.

T Ng

Tina Ng
Dispute Services Officer
As delegate of the Registrar