WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-3498/19**
Appellant:	**Dale Michael Williams**
Respondent:	**Kypreos Civil Engineering Pty Ltd**
Date of Decision:	**11 March 2020**
Citation:	**[2020] NSWWCCMA 50**

Appeal Panel:	
Arbitrator:	**Marshal Douglas**
Approved Medical Specialist:	**Dr Julian Parmegiani**
Approved Medical Specialist:	**Dr Patrick Morris**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 9 October 2019 Dale Michael Williams (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Associate Professor Michael Robertson, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 11 September 2019.

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

   - the assessment was made on the basis of incorrect criteria, and
   - 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 *Workplace Injury Management and Workers Compensation Act 1998* (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 Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

RELEVANT FACTUAL BACKGROUND

6. The appellant while working for Kypreos Civil Engineering Pty Ltd (the respondent) on 17 December 1991 was shovelling dirt to expose conduit that was live. He was electrocuted. It is agreed between the parties that the appellant suffered an agreed psychological injury as a consequence of that. The appellant also says that he suffered an organic brain injury. The respondent disputes that.

7. The respondent made weekly payments of compensation to the appellant until 26 December 2017. Preceding that, the appellant had been examined on 12 January 2017 by Dr Martin Allan, a consultant psychiatrist, at the request of the respondent's insurer. In a report of that date Dr Allan advised the respondent's insurer that he had assessed the degree of the appellant's permanent impairment resulting from the psychiatric injury the appellant suffered on 17 December 1991 to be 19% whole person impairment. On 14 March 2017 the respondent's insurer wrote to the appellant advising him of Dr Allan's assessment and that his entitlement to receive weekly payments of compensation "are likely to reach the 260 week limit early in 2018". On 25 September 217 the respondent's insurer again wrote to the appellant advising him that "your last date of payment will be 27 December 2017 for the gross amount of $1,879.04 for the period 10/12/2017 to 25/12/2017".

8. Thereafter correspondence was exchanged between the appellant's solicitors and the respondent's insurer, the upshot of which was that the insurer denied liability to pay weekly compensation to the appellant or compensation for the cost of his medical treatment. The insurer's denial of liability to make weekly payments of compensation was, in substance, on the basis that the appellant had received weekly compensation for a total period of 260 weeks and did not have a permanent impairment from any compensable injury in excess of 20%, and accordingly, by force of s 39 of the *Workers Compensation Act 1987* (the 1987 Act) the appellant's entitlement to receive weekly payments of compensation had, according the insurer, come to end. The insurer's denial to pay compensation to the appellant for the organic brain injury the appellant said he had suffered, was on the basis that the did not suffer such an injury.

9. On 15 July 2018, the appellant registered with the Commission an Application to Resolve a Dispute (ARD) seeking determination of his claim for weekly payments of compensation. A delegate of the Registrar referred the matter to Arbitrator Mr John Isaksen who on 13 August 2019 made the following determination, with the consent of the parties:

> "1. The applicant ceased to receive weekly payments of compensation from 25 December 2017 due to the provisions of section 39 of the 1987 Act.
>
> 2. This matter is now remitted to the Registrar for referral to an Approved Medical Specialist (AMS) as follows:
>
> Date of injury: 17 December 1991
> Body Part: Psychological injury
> Method of Assessment: Whole Person Impairment
>
> 3. The following documents are to be referred to the AMS:
>
> (a) Application to Resolve a Dispute with attachments;
> (b) Application for Assessment by an Approved Medical Specialist, filed by the applicant, with attachments;
> (c) Reply with attachments;
> (d) Response to Application for Assessment by an Approved Medical Specialist with attachments.
>
> 4. The matter is remitted back to an Arbitrator following upon the provision of the Medical Assessment Certificate (MAC) for determination of any outstanding claims for weekly payments of compensation and/or the claim made by the applicant that he sustained organic brain injury as a result of the injury of 17 December 1991."

10. Following that, a delegate of the Registrar referred the medical dispute relating to the degree of permanent impairment of the appellant from the agreed psychiatric injury to the AMS to assess.

PRELIMINARY REVIEW

11. 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

12. During its preliminary review, the Appeal Panel determined, for reasons which are explained below, that the MAC did contain a demonstrable error. The Appeal Panel therefore had to reassess the medical dispute that had been referred for assessment. The Appeal Panel notes that neither party requested the appellant be re-examined but the Appeal Panel considered that in order for it to reassess the medical dispute that had been referred for assessment, one of the AMSs that had been appointed to the Appeal Panel would need to examine the appellant. The Appeal Panel appointed AMS Dr Julian Parmegiani to conduct this examination. Dr Parmegiani examined the appellant on 20 February 2020 and reported on his examination to the Appeal Panel on 27 February 2020.

FRESH EVIDENCE

13. On 22 February 2020 the appellant sought to have the Appeal Panel receive into evidence a report dated 20 August 2019 of Dr Ross Mellick, a neurologist, and a report dated 8 October 2019 of Dr Janine Stewart, a neuropsychologist. The appellant, through his solicitor, also made written submissions addressing the Appeal Panel on why the Appeal Panel should receive those reports into evidence.

14. It is apparent from the report of Dr Mellick that he examined the appellant at the request of the insurer's solicitor. It is apparent from the report of Dr Stewart that she conducted a neuropsychological assessment of the appellant also at the request of the insurer's solicitor.

15. The respondent filed with the Commission an Application to Admit Late Documents on 4 February 2020. The appellant's written submissions to the Appeal Panel, regarding whether the Appeal Panel should receive the reports into evidence, indicate that the appellant had not been served with the reports before the respondent had filed the Application to Admit Late Documents with the Commission. The appellant submits, in substance, that the reports are relevant to an issue relating to the assessment of the degree of his permanent impairment resulting from his psychiatric injury, specifically whether part of his impairment is due to an organic brain injury.

16. The respondent's solicitor also prepared written submissions dated 25 February 2020 addressing the Appeal Panel on whether it should receive the reports into evidence. The respondent submits there is a dispute between it and the appellant regarding whether the appellant suffered an organic brain injury and that this "legal issue" has not been the subject of any determination by the Commission. The respondent submits that the reports of Dr Mellick and Dr Stewart relate to whether the appellant suffered an organic brain injury from the event of 17 December 1991. The respondent submits that "there is no benefit in having the medical reports of Dr Mellick and Dr Stewart forwarded to the [Appeal Panel] in circumstances where there is not finding of an arbitrator" relating to whether the appellant has suffered an organic brain injury from the incident on 17 December 1991.

17. Section 328(3) of the 1998 Act provides that evidence that is fresh evidence or evidence in additional to or in substitution for the evidence received in relation to a medical assessment appealed against may not be given on an appeal by a party unless the evidence was not available to the party before the medical assessment and could not reasonably have been obtained by the party before that medical assessment.

18. The Appeal Panel is satisfied that the criteria specified by s 328(3) are met in this case and that it should receive into the evidence the reports of Dr Mellick and Dr Stewart. The appellant did not have those reports before the medical assessment of the AMS. In the Appeal Panel's view the reports deal with an issue directly relevant to the medical dispute referred for assessment and that is whether the appellant's present symptoms and impaired function consequent upon his present symptoms are due, even in part, to an organic brain injury.

EVIDENCE

19. In addition to AMS Dr Parmegiani's report, which is extracted below in "Findings and Reasons", and the reports of Dr Ross Mellick dated 20 August 2019 and Dr Janine Stewart dated 8 October 2019, 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

20. The AMS examined the appellant on 5 September 2019. He set out the history he obtained within Part 4 of the MAC, which included this relating to the circumstances of the appellant's injury, onset of symptoms and subsequent related events:

> "Mr Williams is a 60-year-old man. He has one child from a previous relationship, a child with his wife and as step-child, and they have eight grandchildren in combination.
>
> Mr Williams has been unable to work since 2008. His most recent employment at a warehouse was terminated in the context of his declined mental health.
>
> Mr Williams' story is most complex and there is an extensive brief of evidence.
>
> On the date of injury Mr Williams sustained an electrocution injury, which whilst not fatal, has had significant physical sequelae including chronic discomfort from upper limb injuries and chronic psychiatric symptoms.
>
> Contemporaneous observations from clinicians around the time of the incident document the presence of PTSD, e.g. Mr Langmead, Psychologist, Dr Millar, Psychiatrist, Dr Keshava, Independent Medical Examiner Psychiatrist, Dr Douglas, Psychiatrist, and Dr Couldridge, Treating Doctor.
>
> Mr Williams has had a series of more recent assessments. Dr Allnutt examined him in August 2017 noting the consensus view of his suffering chronic posttraumatic stress disorder, noting the issue of Mr Williams' marked cognitive impairment. Dr Allnutt assesses 24% whole person permanent impairment noting class 3 impairments in Tables 11.1, 11.2, class 2 impairments in Tables 11.3 and 11.4, and class 4 impairments in Tables 11.5 and 11.6.
>
> Dr Allen examined Mr Williams in January 2017. Dr Allan noted inter alia the electrocution incident and Mr Williams' chronic psychological disturbance. Dr Allan notes diagnoses of a major depressive disorder, generalised anxiety disorder and panic attacks. Dr Allan states maximum medical improvement and assesses 19% WPI noting class 2 impairment in Tables 11.1 and 11.4, class 3 impairment in Table 11.2, class 1 impairment in Table 11.3, class 4 impairment in Table 11.5 and class 5 impairment in Table 11.6.

A critical issue is the presence of a putative neurocognitive disorder that has been investigated extensively including a neuropsychological assessment conducted by Dr McMahon who notes the presence of comorbid posttraumatic stress disorder and a major neurocognitive disorder. Dr McMahon interprets an extensive neuropsychological battery noting 'marked impairment of intelligence, executive functioning and some aspects of memory'. Dr McMahon references radiological evidence of 'mild diffuse cerebral atrophy particularly in the frontal and parietal region'.

On this issue Dr Teychenne provides a detailed assessment of Mr Williams' neurological status. Dr Teychenne states 'I consider that the patient had sustained an organic brain injury as a result of the electrocution injury. He had evidence of significant cognitive deficits. In particular he had evidence of a nominal dysphasia and acquired dyslexia, visuospatial deficits and memory deficit, a concentration deficit and psychomotor slowing. I consider that his organic brain deficit was a direct result of the electrocution sustained on 17 December 1991. I considered that Mr Williams was basically unemployable'. Dr Teychenne then notes 29% whole person permanent impairment with reference to Table 13.5 of the Guides and 10% impairment noting a putative spinal cord injury attributable to the condition."

21. The AMS recorded, also within Part 4 of the MAC, that the appellant's present symptoms, as reported by the appellant and his wife were:

"Mr Williams and his wife report that there has been little improvement in his memory. He has difficulties with written comprehension and often has problems following conversations or simple instructions. He frequently misplaces belongings and repeats himself. He often forgets the names of family members. He cannot follow the plots of television programs and cannot read newspapers beyond following his beloved Richmond Tigers AFL Club. He has little capability to engage with any current affairs or awareness of events. He reports he is frequently embarrassed by saying 'stupid things', commented upon by his young grandchildren. He 'gets lost' in familiar environments and will need to have someone escort him when leaving the family home. His wife coordinates all of his appointments. There seems to be one residual capability; Mr Williams reports that he can assemble his own medication.

Beyond Mr Williams's marked cognitive problems, he has difficulty with chronic anxiety including headaches, gastrointestinal disturbance, excessive worry, and psychologically decompensating. He is irritable and at times prone to episodes of anger. He has middle insomnia and unrefreshing sleep. He spends much of the day unsettled. He has little interest in previously enjoyed activities and is often not interested in watching AFL. He has a sense of self-reproach, guilt and diminished self-worth. He describes chronic suicidal ideation but he has made no recent attempts. He is noted to be emotionally incontinent, frequently tearful and labile which at times has been a source of embarrassment for those around him.

He continues to experience some intrusive symptoms of PTSD frequently triggered by stimuli such as electrical storms or electricity fuse boxes. He refuses to plug or unplug belongings and will not go near the fuse box at the family home. He is hypervigilant around any form of electrical equipment."

22. With respect to how the appellant functions within the several PIRS categories, other than concentration, persistence and pace, the AMS recorded the following, also within Part 4 of the MAC

"Self-Care and personal hygiene – Mr Williams states that he has not brushed his teeth for two decades. He must be frequently prompted to shower. He cannot prepare food and otherwise will default to takeaway or ready-prepared meals. His wife coordinates all appointments. He cannot be left alone with his grandchildren.

Social and recreational activities – he regularly plays darts with his wife on Wednesdays at a local club. This is a very familiar environment with people he has known for many years. He is otherwise reluctant to socialise in unfamiliar environments or to accept invitations to any occasions with people he does not know and will not accept visitors to his home.

Travel – he cannot leave home without the assistance of his wife or other responsible adult due to phobic anxiety and his propensity to become lost.

Social functioning – he has lost numerous friendships over many years because of his cognitive impairment and chronic anxiety. There have been no instances of domestic violence nor threatened or actual separation.

Employment/adaptation – there was a brief period of employment as noted in the early 2000s ending in 2008 in the context of his severe psychological disturbance and cognitive impairment. He has since been long-term job-detached. He has not performed any productive activity around the house and anything he does attempt his wife has to supervise.

23. The AMS repeated that detail within Table 11.8 appended to the MAC, by way of explaining his reasons for his ratings of the appellant's impaired function in those categories. The AMS rated the appellant's impaired function from his psychological injury in those categories as, respectively, 3, 3, 2, 2 and 4. Within the table the AMS also recorded that he had rated the appellant's impaired function in the concentration, persistence and pace as 3, explaining his reasons for doing so as "extensive cognitive impairment in multiple domains partly attributable to chronic PTSD and major neurocognitive disorder".

24. Within Part 7 of the MAC, the AMS provided this summary of the appellant's injuries and these diagnoses:

> "Mr Williams is a 60-year-old man who sustained a psychological injury following an electrocution incident in 1991. Mr Williams has been plagued with a chronic psychopathological disturbance with variable features of posttraumatic stress disorder, generalised anxiety and depression. Mr Williams' clinical presentation - at least per review of documentation from the early 1990s - was more consistent with an acute PTSD although the current clinical presentation seems to have evolved into more generalised anxiety and persistent depressive disorders.
>
> The critical issue in this matter appears to be the nature and extent of Mr Williams' neurocognitive disorder. There is clear neuropsychological and clinical evidence of Mr Williams having significant cognitive deficits attributable to pathology directly affecting the central nervous system. The best available independent advice on this matter would indicate that this was attributable to the electrocution incident, although it is important to note that Mr Williams has longstanding risk factors to cerebrovascular disease and imaging evidence of microvascular disease suggesting there was likely a component of a vascular dementia.
>
> Regardless of cause, Mr Williams' cognitive impairment is partly attributable to a separate injury affecting the nervous system of which there was an assessment of impairment conducted by Dr Teychenne. This is best addressed in assessment of whole person permanent impairment arising from psychological injury, by apportioning the relative contribution of his observed cognitive deficits attributable to the presumed organic mental syndrome, and that of the observed chronic anxiety state. I believe this is best done through considering this issue on each of the individual categories on the PIRS."

25. In answer to a standard question within the MAC template, relating to whether the appellant was “claiming for any body part outside your filed of expertise”, the AMS answered, “yes, there appear to be assessments of impairments for an organic mental syndrome (major neurocognitive disorder) as well as a spinal injury”.

26. The AMS said this in Part 9 of the MAC with respect to the facts on which he had based his assessment:

> “I have taken the position that the considerable prima facie whole person permanent impairment is in part attributable to the major neurocognitive disorder which is a separate injury from the observed chronic anxiety disorder. Mr Williams has had a longstanding posttraumatic stress disorder that has evolved into a clinical picture more consistent with generalised anxiety disorder and chronic depression with crosscutting features of PTSD that are often triggered by salient cues.
>
> Mr Williams’ impairment on Table 11.1 on prima facie evaluation would be a class 4 impairment, however I would submit that roughly 50% of this is attributable to the organic brain syndrome which would average to a class 2 impairment. Similarly the observed impairment of Table 11.5 would be a class 4 impairment (as observed by Dr Allnutt and Dr Allan, however given the equal attribution to the effects of his chronic depression and anxiety and the major neurocognitive disorder, this would average to a class 2 impairment.
>
> Mr Williams’ incapacity for employment was partially attributable to cognitive dysfunction but more to his anxiety and therefore class 4 impairment is an appropriate compromise as against the prima facie evaluation of class 5 impairment.”

27. The AMS also said at Part 10a of the MAC that, “I have situated the major neurocognitive disorder as having equal weighting to the observed psychological injury in domains of impairment on Tables 11.1, 11.5 and 11.6”.

28. As already mentioned, in Table 11.8 appended to the MAC, the AMS set out his ratings of the appellant’s impairment for the several PIRS categories, which were, starting with 11.1 and ascending to 11.6, 3,3,2,2,2 and 4. The AMS noted that the median of those ratings is 3 and the aggregate 16. Based on that, and in accordance with the Conversion Table 11.7 in [11.20] of the Guidelines, the AMS assessed the appellant’s whole person impairment from his psychiatric injury to be 16%.

SUBMISSIONS

29. Both parties made written submissions with respect to the how the Appeal Panel should deal with the appeal. They are not repeated in full, but have been considered by the Appeal Panel.

30. In summary, the appellant submits that the AMS erred by assessing the appellant’s impairment for an organic mental syndrome because that was outside the AMS’s field of expertise. The appellant further submits that the AMS failed to explain or provide an adequate explanation for how he apportioned the appellant’s impairment between the appellant’s psychiatric injury and the appellant’s organic brain injury and that the apportionment the AMS made was arbitrary and inconsistent with the history the AMS obtained.

31. In reply, the respondent submits that the AMS explained that the appellant's impairment was due to both the appellant's psychological condition and a cognitive disorder of unknown origin. The respondent submits that whilst the AMS did not have the necessary training to assess the appellant's cognitive impairment in accordance with the provisions of Chapter 13 of AMA 5, the AMS nevertheless explained why he deducted "a portion" of impairment due to the neurocognitive disorder. The respondent says that "the AMS surmised that the appellant's presentation and impairment could not be explained solely on the basis of a psychological injury" and that there was another factor being "a neurocognitive condition".

    The respondent submits that the AMS is qualified to assess the appellant's permanent impairment due to the appellant's psychological injury and did so and apportioned the "residual impairment" to the cognitive deficits. The respondent submits that the AMS provided adequate and clear reasons for attributing part of the appellant's impairment to the cognitive deficits. The respondent submits that "the AMS has made a clinical determination that a portion of the overall impairment was attributable to the psychological injury and residual impairment to a disorder of the nervous system". The respondent submits that the methodology the AMS adopted does not constitute a demonstrable error.

FINDINGS AND REASONS

32. 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.

33. 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.

34. An AMS is required to set out the actual path of the reasoning by which he or she arrived at his or her assessment.[1] The reasons do not need to be comprehensible to a person with no medical expertise. If a conclusion of an AMS is self-evident in a medical sense, then the reasons need not be extensive. If however, a conclusion is medically contestable, then an AMS will need to address and explain the evidence more extensively such that the path by which she or he made the assessment is exposed.[2]

35. The MAC as a whole needs to be considered in order to comprehend fully the reasons of the AMS. When that is done, in the Appeal Panel's view, the AMS has sufficiently disclosed the path of his reasons that led him to the view that the appellant's impaired function was due to both the psychiatric injury the appellant suffered on 17 December 1991 as well as cognitive deficits attributable to an organic brain pathology. The AMS, in describing the appellant's present symptoms, noted that the appellant has marked cognitive problems and, when examining the appellant, found that the appellant had limited general knowledge and could not nominate the Prime Minister and had little knowledge of current affairs and had little sense of where he was. The AMS also, when summarising the appellant's injury and providing diagnoses, explained that the appellant's significant cognitive deficits are, based on the evidence, attributable to pathology directly affecting the appellant's central nervous system. As indicated, in the Appeal Panel's view, those reasons of the AMS sufficiently explained why the AMS concluded the appellant's impaired function was due to both the appellant's psychiatric injury and the appellant's cognitive deficits. Different clinical examiners may have come to different views on this, but that does not of itself indicate error, merely the capacity for different examiners to have different views.

---

[1] See *Wingfoot Australia Partners Pty Ltd v Kocak* [2013] 252 CLR 480.
[2] See *Vitaz v Westform* (NSW) Pty Ltd [2011] NSWCA 254 at [34].

36. In the Appeal Panel's view the AMS did not, however, in a cogent or comprehensible way reveal the path of his reasoning with respect to his conclusion about the extent to which the appellant's total impairment is due to the appellant's psychological injury and the extent to which it is due to cognitive deficits that the AMS considered were consequent upon brain pathology. To say that another way, whilst the AMS sufficiently exposed his reasons with respect to his conclusion that the appellant's impairment was due to both to the appellant's psychological injury and organic brain pathology, the AMS did not in a clear or adequate way explain his conclusion regarding the extent to which the appellant's impaired function was due to the appellant's psychiatric injury and the extent to which it was due to brain pathology.

37. Indeed, the explanation the AMS provided was contradictory and, therefore confusing, with respect to the extent to which the appellant's functioning in the areas of self-care and personal hygiene, and employability was due to his psychiatric injury and the extent to which it was due to his brain pathology. The AMS in Part 9 of the MAC said, with respect to the appellant's functioning in self-care and personal hygiene, that "roughly 50%" of the appellant's impairment is attributable to organic brain syndrome which would "average" to a class 2 impairment. He said likewise in 10a in that he said he "had situated the major neurocognitive disorder as having equal weighting to the observed psychological injury in domains of impairment on Tables 11.1". However, in Table 11.8 appended to the MAC, the AMS rated the appellant's impairment as being class 3 with respect to the appellant's functioning in this area.

38. The AMS in Part 9 of the MAC said, with respect to the appellant's impairment in the area of employability, that the appellant's "incapacity for employment was partially attributable to cognitive dysfunction but more to his anxiety and therefore class 4 impairment is an appropriate compromise as against the prima facie evaluation of class 5 impairment". However, in Part 10a of the MAC he said something different, being that he had "situated the major neurocognitive disorder as having equal weighting to the observed psychological injury in domains of impairment on Tables ….11.6".

39. Given that, the Appeal Panel accepts the appellant's submission that the AMS did not provide clear and adequate reasons with respect to the AMS's assessment of the appellant's impairment from his psychiatric injury. The issue of the extent to which the appellant's impairment is due to his psychiatric injury and the extent to which it is due to any organic brain pathology is not something that is self-evident, in a medical sense, and is a medically contestable issue. In that circumstance, clear and cogent reasons for the AMS's assessment were required. The Appeal Panel considers the AMS's reasons were not so.

40. Given that, the Appeal Panel finds that the MAC does contain a demonstrable error.

41. In that circumstance, the Appeal Panel is required to reassess the medical dispute that was referred for assessment.[3] As mentioned much earlier, the Appeal Panel considered that it needed to re-examine the appellant to enable it to reassess the medical dispute and AMS Dr Parmegiani was appointed to do that. Dr Parmegiani examined the appellant on 20 February 2020 and provided the Appeal Panel with the following report from his examination:

> "Mr Dale Williams was assessed at the request of the Medical Appeal Panel. The assessment focussed on his current psychiatric symptoms and associated impairment. Mr Williams' wife, Karen Williams, was present during the interview.
>
> Demographic Data
> Mr Dale Williams is a 60-year-old man currently living in Albury with his wife age 55. She works fulltime in a factory. Mr Williams has not worked for many years.

[3] *Roads and Maritime Services v Rodger Wilson* [2016] NSWSC 1499 at [26].

Psychiatric Symptoms

Mr Williams was severely depressed. His self-esteem was low, and he felt that life was not worth living. He constantly thought about suicide, but he did not formulate a plan. He was reluctant to discuss his chosen method because his wife was present.
Mr Williams hinted he would use a firearm, but he did not possess one. Mr Williams felt guilty about the impact of his psychiatric problems on his relationship. He felt he was a burden on others. He slept poorly between 12 midnight and 8am, with the help of medication. Mr Williams' mood was reactive, and he enjoyed visits from his grandchildren. He did not however identify other recreational activities.

Mr Williams lacked appetite, and he did not eat breakfast or lunch. He ate excessively at night, but his weight remained stable. Mr Williams lacked energy, motivation and concentration. He was unable to read more than a few lines before losing focus.
Mr Williams felt hopeless about his future. He repeated a number of times that he should have died in the accident. Mr Williams continued to fear electricity. He felt terrified during lightning storms. He felt anxious when using a toaster, and his wife changed lightbulbs. Mr Williams felt anxious in crowds. He did not drink alcohol. He was prescribed Duloxetine 90mg per day, an antidepressant. He took Clonazepam 4mg per day, a benzodiazepine tranquiliser. Mr Williams was not under the care of mental health professionals because he did not find psychological treatment helpful in the past.

Mental State Examination

Mr Williams was a 60-year-old man of above-average weight. He was punctual for his appointment. He was irritable and emotionally labile. He had a tendency to grimace when he became more upset. Mr Williams expressed frustration with his cognitive deficits. He explained that he was unable to concentrate and think clearly. He said, 'I am f***ing sick of having a brain injury.' He believed that the electrocution incident had irreparably damaged his brain. He struggled to express himself, and he often asked me to repeat questions. Mr Williams was however able to recall clearly recent events. He recalled his interactions with other medicolegal assessors. He remembered using public toilets before attending the interview, and where these were located. He was oriented in time, place and person. From a clinical perspective, Mr Williams' presentation was consistent with a chronic Posttraumatic Stress Disorder, with a secondary Major Depressive Disorder. His cognitive deficits were consistent with his Major Depressive Disorder. His presentation is described in research literature as pseudodementia. This was consistent with the opinion expressed by Dr Ross Mellick in his report dated 24 December 2019. Similarly, Dr Jeanette Stewart indicated in her report of 29 October 2019, that severe depression and anxiety can independently lead to difficulties with effortful processing.

Current Function

Mr Williams' impairment is rated in accordance with the WorkCover Guides for the Evaluation of Permanent Impairment.

Self-care and personal hygiene
Class 3.
Mr Williams lived at home with his wife. She managed the family finances because he was unable to concentrate. Mr Williams did not shower for 3-4 days, until his wife encouraged him to do so. He performed some domestic work, including washing and mowing lawns. He drove his wife to local shops, but he remained in the car because he felt too anxious in crowds. On balance, it is unlikely that Mr Williams could live independently without regular support.

Social and recreational activities
Class 3.
Mr Williams and his wife visited mutual friends every 2-5 weeks. Mr Williams did not visit friends alone, and he did not initiate spontaneous recreational activities. He saw one friend from time to time, whom he described as ‘my support person.’ Mr Williams visited him when he felt upset, and he ventilated his distress.

Travel
Class 2.
Mr Williams was able to travel alone to familiar areas. He visited his general practitioner and local shops. He did not however travel to unfamiliar areas without a support person.

Social functioning
Class 2.
Mr Williams often lost his temper with his wife. He lost contact with most friends. He did not experience marital separations or episodes of domestic violence.
Concentration, persistence and pace
Class 4.
Mr Williams often lost his track of thought during the interview. Questions had to be repeated.

Employability
Class 5.
Mr Williams did not undertake activities that could reasonably attract remuneration. He was too depressed, irritable and emotionally labile.”

42. The Appeal Panel adopts the history Dr Parmegiani obtained with respect to the appellant’s present psychiatric symptoms and the findings of Dr Parmegiani. The Appeal Panel also considers that the ratings of Dr Parmegiani with respect to the several PIRS category are correct, for the reasons that Dr Parmegiani has set out in his report to the Appeal Panel. In the Appeal Panel’s view it is apparent, based on the history that Dr Parmegiani obtained and his findings from his examination of the appellant, that the appellant’s impaired function is entirely due to psychiatric symptoms he has resulting from his injury. In other words, the Appeal Panel considers that the appellant’s present impaired function in all the PIRS categories is entirely explicable by reference to psychiatric symptoms and not to any other pathology if such pathology indeed exists.

43. Arranging the classes in ascending order: 2,2,3,3,4,5. Median = 3. Aggregate = 19. This is equivalent to a whole person psychiatric impairment rating of 24%.

44. For the sake of thoroughness only, the Appeal Panel observes that its conclusion with respect to the appellant’s impaired function being wholly due to the appellant’s psychiatric injury, is different from the opinion the AMS reached and that the Appeal Panel had found the AMS concluding that the appellant’s impairment is due to both his psychiatric injury and brain pathology did not demonstrate any error in the MAC. That is of no consequence however, given that the MAC had to be revoked, because the Appeal Panel found the MAC contained a demonstrable error on another issue, and the Appeal Panel therefore had to reassess the medical dispute. The fact that the Appeal Panel came to a different conclusion than the AMS on this matter, in that the Appeal Panel found that the appellant’s impairment is due only to his psychiatric injury, only indicates, again, the fact that different examiners and assessors (ie, the Appeal Panel and the AMS) can hold different opinions.

45. For these reasons, the Appeal Panel has determined that the MAC issued on 11 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.

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **3498/19**
Applicant: **Dale Michael Williams**
Respondent: **Kypreos Civil Engineering Pty Ltd**

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 Associate Professor Michael Robertson 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 AMA5 Guides**	**% WPI**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Sub-total/s % WPI (after any deductions in column 6)**
Psychiatric/ psychological injury	17/12/91	Chapt 11	Chapt 14	24%	-	24%
Total % WPI (the Combined Table values of all sub-totals)					**24%**	

Marshal Douglas
Arbitrator

Dr Julian Parmegiani
Approved Medical Specialist

Dr Patrick Morris
Approved Medical Specialist

11 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*.

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar