WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-3399/19**
Appellant:	**Aaron Lee Darcy**
Respondent:	**P & T Formworking & Welding Pty Limited**
Date of Decision:	**2 April 2020**
Citation:	**[2020] NSWWCCMA 66**

Appeal Panel:	
Arbitrator:	**R J Perrignon**
Approved Medical Specialist:	**Dr Tommasino Mastroianni**
Approved Medical Specialist:	**Dr Michael Fearnside**

BACKGROUND TO THE APPLICATION TO APPEAL

1. The appellant worker, Mr Darcy, appeals from the Medical Assessment Certificate of Approved Medical Specialist Dr Mellick dated 24 September 2019.

2. Mr Darcy was injured on 3 June 2017. While he was working at the bottom of a culvert, a co-worker at the top of the culvert dropped a segment of hose which hit Mr Darcy on the back of the head.

3. He claimed compensation for whole person impairment in respect of the brain, cervical spine and both shoulders. By consent, those body parts were referred to the Approved Medical Specialist for assessment of whole person impairment as a result of injury on 3 June 2017.

4. On 24 September 2019, Approved Medical Specialist Dr Mellick assessed a 0% whole person impairment (0% neurological – brain; 0% cervical spine; 0% right upper extremity – shoulder; 0% left upper extremity – shoulder) because he found no symptoms or signs establishing abnormalities of an organic nature involving the brain, the cervical spine or the shoulder.

5. The worker appeals from this assessment on the bases that it contains demonstrable error and the application of incorrect criteria, and seeks re-examination by the Appeal Panel.

6. On 18 November 2019, the Registrar by his delegate was satisfied that the ground of demonstrable error was made out, and referred the matter to this Appeal Panel for determination.

7. On 10 October 2019, the Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment (*Guidelines*)*. Having identified error on some of the grounds relied on by the appellant, it referred the appellant for examination by Dr Mastroianni, whose report and assessment appears below.

Submissions

8. The Appeal Panel has had regard to the written submissions filed by both parties. It is unnecessary to set them out here in full, but appropriate to summarise them as follows.

9. The appellant worker submits as follows.

    (a) The Approved Medical Specialist failed to have regard to or grapple with the reports of:

        (i) Dr Anderson, who identified grossly restricted movements in both shoulders and assessed a 25% whole person impairment,

        (ii) treating neuropsychologist Corrine Roberts, who diagnosed concussion and took a history of symptoms consistent with the appellant's statement, and

        (iii) the appellant's own statement.

    (b) He failed to give reasons for disagreeing with the assessment of Dr Milder.

    (c) He wrongly assumed that Associate Professor Jankelowitz considered there was no assessable impairment.

    (d) He failed to record range of movement of either shoulder, and failed to assess the shoulders.

    (e) He failed to consider whether there was impairment of the shoulders due to other disorders.

    (f) He failed to consider whether there was impairment resulting from musculo-ligamentous strain to the neck and shoulders, confining himself to a consideration of whether there was a neurological basis for the appellant's complaints.

    (g) He failed to give reasons for finding that the appellant has recovered from soft tissue injuries, despite the gross reduction in range of movement of the shoulders.

    (h) He failed to assess cerebral impairment.

    (i) He failed to conduct tests of mental status, cognition or integrative function in accordance with Part 13.3d of the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* 5th edition (AMA5), basing his assessment solely on the appellant's responses during the course of history taking.

    (j) He failed to provide reasons for rejecting the appellant's evidence and complaints.

10. The respondent employer submits in summary as follows.

    (a) The Approved Medical Specialist did take account of the reports of Dr Anderson and Ms Roberts because he referred to them. He did not discuss their contents, perhaps because they were treaters and not independent examiners.

    (b) He discussed in sufficient detail the reports of Dr Milder, Dr O'Neil and Associate Professor Jankelowitz.

(c) In respect of Dr Milder's report, he made it clear that he did not find similar symptoms with respect to the cervical spine and brain.

(d) He recorded that Associate Professor Jankelowitz did not regard there to be any assessable impairment, but did not suggest that Associate Professor Jankelowitz made an assessment of whole person impairment and found no assessable impairment: submissions, par 2.4(c) to (e).

(e) On examination, the Approved Medical Specialist found there was no abnormality, no wasting of the shoulder and no palpable abnormality over the shoulder joints.

(f) It was sufficient for the Approved Medical Specialist to record that there was no gross loss in range of motion, without recording his measurements in tabular form.

(g) The Approved Medical Specialist was not required to conduct cognitive testing in circumstances where, on examination of the cranial nerves, he could find no impairment.

Reasoning of the Approved Medical Specialist

11. The Approved Medical Specialist examined the worker on 11 September 2019. He noted that the Registrar had referred for assessment the brain, cervical spine and both shoulders. He. He took a history of injury on 3 June 2017. He noted that he had received the Application to Resolve a Dispute and Reply with attached documents, listed in the Registrar's referral. These included the reports of Dr Anderson and Ms Roberts.

12. He noted in detail the worker's current symptoms, including pain on the right side of the head, the right side of the neck, and the top right shoulder. He described the pain distribution. He noted that the worker had taken five days off work as a delivery driver due to pain, and that in previous jobs he had suffered pain at work. He noted the worker did not take alcohol or drugs, except for cannabis on a weekly basis.

13. In respect of the brain, he observed at [5]:

> "On examination, Mr Darcy gave a clear history and exhibited no abnormality of cognition. At no time during the course of the consultation or physical examination was there any evident impairment of cognitive grasp or his ability to sustain attention or comprehend.
>
> There was no abnormality of the normal rhythm of gait or of accessory arm, leg or trunk movements.
>
> ……
>
> Examination of the cranial nerves revealed no abnormalities."

14. He noted a report of a CT scan of the brain performed on 3 June 2017, which demonstrated "no evidence of intracranial pathology".

15. In respect of the neck, he noted there was no impairment of cervical movement when the worker got to his feet to walk around during consultation and history taking. On examination, he found no wasting of paracervical or shoulder girdle muscles, noting: "He was well muscled".

16. However, he noted at [5]:

> "On formal testing of cervical movements, cervical rotation to right and left was grossly impaired and considerably less than had been observed at an earlier time during the consultation. The impairment was not associated with involuntary muscle spasm or guarding. There was no abnormality of tone, coordination or sensation and the deep tendon reflexes were present and symmetrical."

17. In respect of the shoulders, he found no palpable abnormality of the shoulder joints during movement. As indicated above, he found no wasting of the shoulder muscles, describing the worker as 'well-muscled'. However, he recorded at [5]:

> "There was gross impairment of shoulder movement bilaterally and also marked impairment of power production globally in both upper extremities with a prompt giving-way phenomenon."

18. Though the lower extremities were not referred for examination, he appears to have examined them, observing at [5]:

> "There was also global impairment of power production involving both lower extremities unassociated with abnormalities of tone or coordination. The deep tendon reflexes were present and symmetrical in the lower extremities."

19. He did not set out his measurements of cervical spine movement or bilateral shoulder movements.

20. He offered the following summary of injuries at [7]:

> "There is no evidence of any deeply sited intra-cranial, spinal, nerve root, proximal or distal peripheral nerve injury, to have occurred at the time of the injury. There are marked non-organically functional abnormalities on examination."

21. Though the meaning of this paragraph in its context is not entirely clear, doing our best, we interpret:

    (a) the first sentence to mean that he could identify no current brain, spinal or nerve pathology resulting from injury, and

    (b) the second sentence to mean that the restricted movements of the neck and shoulders were not of organic origin.

22. He added, "There is consistency of presentation in accord with the neurological conclusions presented here." We interpret that to mean that the worker's presentation was consistent with the absence of brain, spinal or nerve pathology.

23. Under the heading, "My opinion and assessment of whole person impairment", he said at [10a]:

> "I do not identify symptoms or signs establishing abnormalities of an organic nature involving the brain, the cervical spine or the upper extremities (either shoulder)."

24. He added at [10b] (emphasis added):

> "It is noted that the radiological investigations performed, directed at the head and cervical spine which included CT scans of the brain and MRI scans, failed to identify any deeply sited intracranial or cervical spine pathology.

> **The details of the injury indicate the probability that the pain he suffered was of muscular and ligamentous origin. The pain that he now reports is clearly not of intracranial origin and there is no evidence of a brain, cervical spine, cervical nerve root or shoulder joint injury.**
>
> **The marked impairment of function which is evident when shoulder movements are tested** needs to be considered in the light of symmetrical, unusually good muscle mass, the gross functional abnormalities of motor function involving both upper extremities and the nature of the injury **does not provide a basis to attribute the clinical picture as it now presents to an organically based mechanism**.
>
> **Mr Darcy should be regarded, therefore, to have fully recovered from any soft tissue injury that occurred at the time of the accident and to now exhibit features which are not due to an underlying, organically based injury to the brain, the cervical spine or the upper or lower extremities.**
>
> With reference, therefore, to AMA5 and the WorkCover Guidelines in relation to the brain, I find 0% whole person impairment; in relation to the cervical spine, 0% whole person impairment; the right upper extremity, 0% whole person impairment, and the right lower extremity, 0% whole person impairment."

25. In summary, the Approved Medical Specialist assessed a 0% whole person impairment on the basis that, notwithstanding the complaints of pain in the head and other body parts, and the limited range of movement of the neck and shoulders, there was no longer any identifiable pathology in the brain, neck or shoulders, and any musculo-ligamentous injury had resolved.

26. He noted in detail the reports of neurologists Dr Milder, Associate Professor Jankelowitz and Dr O'Neil, observing at [10c]:

> "Neither Dr Jankelowitz nor Dr O'Neil regarded there to be an assessable whole person impairment.
>
> The findings I record above are consonant with the body of these reports and I do not identify symptoms or signs establishing abnormalities of an organic nature involving the brain, the cervical spine or the upper extremities (either shoulder). The findings I report are clearly functional and internally consistent with other observations I make, as I report above, and were devoid of any objective diagnostic sign of organic significance."

Consideration and findings

(a) Reports of Dr Anderson, Ms Roberts and applicant's statement

27. The task of the Approved Medical Specialist was to assess whole person impairment in respect of the body parts referred to him, and to make plain his reasons for assessment. To do that, he had first to identify whether there was any impairment in respect of those body parts, and then to determine whether that impairment resulted from injury on 3 June 2017. He found that there was no present pathology of the brain, the neck or shoulders, notwithstanding the complaints of pain, and the gross restrictions of movement in the neck and shoulders. He considered that any pathology resulting from injury had resolved. He gave reasons for his view. Those reasons were patent, and are extracted above.

28. The evidence before him included the reports of Dr Anderson and Mr Roberts, and the statement of the appellant. The Approved Medical Specialist was required to take all the relevant evidence into account, but was not required to refer to every item of evidence. A discussion of the findings of Dr Anderson and Ms Roberts would have been appropriate, but the omission to discuss them does not constitute evidence that he failed to take that evidence into account, and we are not satisfied that he did.

29. The same can be said with respect to the appellant's statement. In any event, he took a history of pain symptoms in the right side of the head, neck and right shoulder, and observed and recorded the gross restrictions of movement in the neck and shoulders. For the reasons which he gave, he was not satisfied that there was ongoing pathology in the body parts referred to him. We can identify no error in his approach, or in his reasoning.

(b) Reasons for disagreeing with the assessment of Dr Milder

30. Dr Milder had assessed a 10% whole person impairment (neurological/brain) and 6% whole person impairment (cervical spine).

31. His findings were summarised in detail by the Approved Medical Specialist, but the Approved Medical Specialist did not detail how his own findings differed from those of Dr Milder. The differences are, however, apparent on the face of the Medical Assessment Certificate, when one reads the Approved Medical Specialist's findings on examination. As indicated, his reasoning for assessing a 0% whole person impairment, notwithstanding the assessment of Dr Milder, were patent, and need no further explanation. We can identify no error.

(c) Incorrect reading of Associate Professor Jankelowitz' report

32. In a report dated 11 August 2018, treating neurologist Associate Professor Jankelowitz expressed the view that the worker continued to suffer neck pain, headaches and a post-concussion syndrome as a result of injury on 3 June 2017. The doctor did not purport to assess whole person impairment in that report, or express any view as to whether impairment was assessable. To the extent Dr Mellick expressed a contrary view at [10c], he was mistaken, but for the reasons given below [41-43], he was entitled to assess cerebral impairment in the way that he did, and we can identify no error in that assessment.

(d) Failure to record range of shoulder movements

33. As indicated, the Approved Medical Specialist did not record his measurements of shoulder movement. He noted at [5], 'gross impairment of shoulder movement bilaterally and also marked impairment of power production globally in both upper extremities with a prompt giving-way phenomenon'. He compared this with the absence of any palpable abnormality of the shoulder joints, and with the absence of muscle wasting. In assessing a 0% whole person impairment, he found by necessary implication that the restrictions of movement were not a reliable measure of impairment.

34. Where range of movement cannot be used as a valid parameter of impairment evaluation, par 2.5 of the Guidelines, at page 10, requires the Approved Medical Specialist to 'use discretion in considering what weight to give other available evidence to determine if an impairment is present'. In this case, the Approved Medical Specialist considered that range of movement as formally measured by him was not a valid parameter of evaluation. He did not select a different method of evaluation, but rather adopted range of movement, having regard to evidence of shoulder movement when the patient was not under formal examination, and which was not measured. In our view, that was not the correct approach, as any evaluation based on range of motion must be measured in accordance with the Guidelines. It amounted to demonstrable error. The certificate, so far as it relates to the shoulders, must be set aside.

(e) Failure to consider other disorders as causative of shoulder restrictions

35. As demonstrable error has been found in respect of the assessment of the shoulders, it is unnecessary to consider this ground.

(f) Failure to consider whether there had been musculo-ligamentous strain of the neck and shoulders

36. Contrary to the submissions of the appellant, the Approved Medical Specialist did not fail to consider whether there had been a musculo-ligamentous strain of the neck and shoulders. He found there had been, and that this had resolved.

(g) Failure to give reasons for finding that the appellant has recovered from soft tissue injuries

37. As indicated, the Approved Medical Specialist recorded that cervical rotation to the left and right was grossly impaired, but did not disclose his measurements, if any. Noting the absence of any wasting of the paracervical musculature and of any restrictions in cervical movement when the appellant walked about, he assessed a 0% whole person impairment. By necessary implication, he found that cervical movement was not an accurate measure of impairment, but failed to adopt an alternative method, or to measure the range of motion relied on by him as accurate, as required by the Guidelines. A finding that there is inconsistency sufficient to warrant a conclusion that range of movement is an implausible measure of impairment requires that the restrictions in movement at least be measured and recorded, so they may be compared objectively with the observed range of movement which is said to be inconsistent with them. That was not done.

38. To make a finding that there was no existing pathology in the neck which was causative of restrictions of movement, the Approved Medical Specialist would at least have to palpate the neck. There is no record of his having done so, and we are not satisfied that he did. In the circumstances, it was not reasonably open to him to find that there was no pathology in the neck as he did.

39. For all these reasons, the assessment of the neck demonstrates error, and the certificate should be set aside so far as it relates to an assessment of the neck.

(h) Failure to assess cerebral impairment

40. Contrary to the appellant's submissions, the Approved Medical Specialist did assess cerebral impairment. For that purpose, it was relevant to consider whether there was any existing pathology or abnormality of the brain. On assessment, he found no abnormality of cognition, no abnormality of gait and no abnormal neurological signs. He had regard to an MRI of the brain, which demonstrated no pathology. It was reasonably open to him to conclude, as he did, that there was no existing pathology and no impairment, notwithstanding the contrary opinions of the treating psychiatrist and neurophysiologist, and the contents of the applicant's own statement. We can identify no error.

(i) Failure to test mental status, cognition or integrative function

41. Par 5.9 of the Guidelines provides:

> "In assessing disturbances of mental status and integrative functioning … the assessor should make ratings based on clinical assessment and the results of neuropsychometric testing, where available.
>
> For traumatic brain injury, there should be evidence of a severe impact to the head, or that the injury involved a high-energy impact.
>
> Clinical assessment must include at least one of the following:

- significant medically verified abnormalities in the Glasgow Coma Scale score
- significant medically verified duration of post-traumatic amnesia
- significant intracranial pathology on CT scan or MRI."

42. None of these three threshold criteria for assessment of mental status, cognition or integrative function was satisfied. There was no significant medically verified abnormality in the Glasgow Coma Scale score, no significant medically verified post traumatic amnesia and no significant intracranial pathology was demonstrated on CT scan or MRI. As the threshold criteria were not satisfied, no clinical dementia rating (CDR) can be constructed.

43. Where, as here, a CDR cannot be constructed, no whole person impairment can be assessed greater than 0%. We identify no error.

(j) Failure to provide reasons for rejecting the appellant's evidence and complaints

44. The reasoning process of the Approved Medical Specialist has been set out in detail above. That reasoning was patent. Except to the extent indicated above in respect of the assessment of the neck and shoulders, we are satisfied that the reasons were adequate to explain the conclusions reached.

Report of Dr Mastroianni

45. Having identified error in respect of the assessment of the neck and shoulders, the appellant worker was referred to Dr Mastroianni to assess whole person impairment (cervical spine, left upper extremity – shoulder; right upper extremity – shoulder). Dr Mastroianni assessed the worker on 5 February 2020. His report of 7 February 2020 appears below.

> **"1. The worker's medical history, where it differs from previous records**
>
> Not applicable.
>
> **2. Additional history since the original Medical Assessment Certificate was performed**
>
> There is no additional information.
>
> **3. Findings on clinical examination**
>
> Examination of the neck reveals normal neck posture. There is no muscle guarding. There is tenderness over the cervical spine, more so in the lower cervical segment with pain being worse on the right side of the neck. Neck movements were restricted in all planes, more so on rotation and tilt, right greater than left. There was asymmetry present on examination which was also noted as he dressed and undressed.
>
> Examination of the upper limbs revealed normal sensation and normal reflexes (biceps, triceps and supinator jerks). He has normal grip strength.
>
> The right shoulder was tender anteriorly and over the point of the shoulder, whilst the left shoulder is not tender.
>
> Neer's test was positive in both shoulders. Both shoulders were restricted primarily by shoulder pain but he also complains of trapezium and neck pain at the extreme of range of movement.

Shoulder Movements

Movement	Right	% Upper Extremity Impairment	Left	% Upper Extremity Impairment
Flexion	100°	5	140°	3
Extension	40°	1	50°	0
Abduction	90°	4	140°	2
Adduction	20°	1	50°	0
Internal rotation	50°	2	70°	1
External rotation	60°	0	90°	0
	Total	13%	**Total**	6%

I assess 13% right upper extremity impairment and 6% left upper extremity impairment which equates to 8% and 4% WPI respectively. (AMA 5, pages 476 to 479, figures 16-40 to 16-46.)

Mr Darcy falls into DRE Cervical Category II (AMA 5, page 392, table 15-5). He has difficulty with housework and recreational activities which he did prior to the accident (swimming and kayaking). In my opinion his neck injury as well as the shoulder injury impact on those activities. He is independent in self-care.

I assess 7% whole person impairment for the cervical spine. There is no deduction applicable for pre-existing condition.

The Claimant presented in a genuine manner and there were no inconsistencies. Though Dr Mellick did not find any symptoms or signs, or establish any abnormalities of an organic nature involving the cervical spine or the upper extremities, my clinical findings are consistent with facet dysfunction of the cervical spine and rotator cuff pathology. I found the same impairment of the cervical spine as did Dr Anderson, but there has been an improvement in shoulder movement since his examination.

Dr Breit found no intrinsic shoulder pathology. I disagree, as I found tenderness in the right shoulder and positive impingement bilaterally, indicative of rotator cuff pathology. Dr Breit assessed 6% whole person impairment (cervical spine). In my opinion, domestic activities are affected by the neck injury and so I have assessed a greater impairment, consistent with the assessment of Dr Anderson.

4. Results of any additional investigations since the original Medical Assessment Certificate

Not applicable."

46. The Panel accepts the reasoning and assessment of Dr Mastroianni.

Conclusion

47. The appeal is allowed in part. The Medical Assessment Certificate dated 24 September 2019 is set aside and replaced with the attached Medical Assessment Certificate.

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*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **3399/19**
Applicant: **Aaron Lee Darcy**
Respondent: **P & T Formworking & Welding Pty Limited**

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 Mellick and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in NSW workers compensation guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5 Guides**	**% WPI**	**WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality (expressed as a fraction)**	**Sub-total/s % WPI (after any deductions in column 6)**
Neurological (brain)	03.06.17			0%	0	0%
Cervical Spine	03.06.17	Chapter 4 Para 4.17-4.21 Activities of daily living- paragraph 4.34 Table 4.2 Modifiers	Chapter 15 Pages 373-431 Table 15-5	7%	0	7%
Right Upper Extremity (right shoulder)	03.06.17	Chapter 2 Pages 10-13 Paragraphs 2.3 to 2.7	Chapter 16 Tables 16-40, 16-43,16-46	8%	0	8%
Left Upper Extremity (left shoulder)	03.06.17	Chapter 2 Pages 10-13 Paragraphs 2.3 to 2.7	Chapter 16 Tables 16-40, 16-43,16-46	4%	0	4%
Total % WPI (the Combined Table values of all sub-totals)					**17%**	

R J Perrignon
Arbitrator

Dr Tommasino Mastroianni
Approved Medical Specialist

Dr Michael Fearnside
Approved Medical Specialist

2 April 2020

I CERTIFY THAT HIS 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*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar