LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON JUSTICE AND COMMUNITY SERVICES
Ms Elizabeth Lee MLA (Chair), Ms Bec Cody MLA (Deputy Chair)
Mr Michael Pettersson MLA

Submission Cover Sheet

Inquiry into Motor Accident Injuries Bill 2018—Exposure Draft and Guide to the Motor Accident Injuries Bill 2018 Exposure Draft

Craig Edwards

Hassan Ehsan

James Treloar

Submission Number: 67 (Part 1)

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Snedden, Andrew

From: Craigs PA <CraigsPA@mej.com.au>
Sent: Friday, 12 October 2018 5:11 PM
To: LA Committee - JCS
Subject: Submissions/Exposure Draft - Motor Accident Injury Bill 2018

To the Committee Secretary,
Standing Committee on Justice and Cummunity Safety,
Legislative Assembly for the ACT,

Dear Sir/Madam,

My name is Craig Edwards and I am a Partner of Maliganis Edwards Johnson, a law firm based in Canberra. I was admitted to Practice over 33 years ago and I have worked continuously in the field of personal injury law in the ACT, throughout that time. I am familiar with the operation of all of the Legislation affecting accident victims in the ACT. During this time in practice I have had the opportunity of advising in excess of probably 3000 injured individuals or their family members.

I wish to make submissions to your Committee and I will be pleased to have the opportunity to speak before the Committee. I believe that I will be in strong position to provide you with details of the effects and benefits of various forms of compensation legislation. I believe that I will be able to give some level of meaningful assistance in your deliberations before you make determinations for the further passage of the Motor Accident Injuries Bill.

The proposed legislation is, in my view, represents a highly detrimental move away from accepted and civilised patterns and procedures whereby accident victims are presently compensated. One is clearly able to envisage an extensive range of circumstances where accident victims will be left destitute. Clearly the families and other dependants of victims will suffer in the absence of appropriate levels and methods of compensation.

The legislation, as drafted, has been designed to cause the following regressive outcomes:

1. Payments of compensation will be massively reduced, across the while spectrum of victims;
2. The discounting factors (whole person impairment findings, contribution factors etc) will aggravate this circumstance;
3. The extension of some treatment expense rights to drivers at fault will only minimally cut into this huge reduction in benefits;
4. The salaries and bonus payments to insurance company Executives will increase parabolically – with an equal reduction in the benefits paid to victims and their families;
5. Power of determination of benefits will rest entirely with the insurers and their employees. The entitlement to have full and proper access to independent and expert advice (legal, medical and actuarial) will be almost totally eliminated.

There will seem to be no argument against the proposition that this draft bill represents bad and ill considered policy.

The ACT will suffer financially at many levels with the devastation of the existing common law and legislative rights of motor accident victims.

The opportunity to expand upon points raised in this submission, in conference, would be appreciated at that time the fuller impact of the draft legislation will hopefully have been considered, along with the details of the draft Bill by your fellow Committee members and indeed the writer. The draft Bill is very lengthy, detailed and complex and on the face of it, it will introduce a system that will simply not function. I will be pleased to have the further opportunity to consider this hurried document and to provide concrete examples of deficiencies in the draft.

Yours faithfully

Craig Edwards

Tracey Brew
Personal Assistant to Craig Edwards | Partner

Maliganis Edwards Johnson
Level 8, 60 Marcus Clarke St, Canberra ACT 2601 | DX 5736
P 02 6257 2999 **F** 02 6257 4422 **E** craigspa@mej.com.au

www.mej.com.au

Maliganis Edwards Johnson

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Submission concerning the Motor Accident Injuries Bill 2018.

1. The current compulsory third party (**CTP**) insurance scheme is governed by the *Road Transport (Third-Party Insurance) Act 2008* (**RTPI Act**). Whilst there can always be improvements to legislation, the current scheme in many ways achieves a fair balance between the rights of injured parties and those responding to claims.

2. Under the current CTP scheme, parties are entitled to be compensated in relation to the following heads of damages:
   - General Damages;
   - Treatment Expenses (past & future)
   - Loss of earning capacity (past & future)
   - Domestic Assistance damages in accordance with the principles enunciated in *Griffiths v Kerkemeyer* (1977) 139 CLR 161; and
   - Damages pursuant to section 100 of the *Civil Law (Wrongs) Act 2002.*

3. The payment of *General Damages* or what is otherwise referred to as *Pain & Suffering Damages* is a longstanding common law right for an injured party. The case law concerning damages at common law is well settled.

4. If passed, the proposed Motor Accident Injuries Bill 2008 (**Bill**) will **actively take away** this right. To this end, I refer to section 198 of the Bill. Section 198 is as follows:

   198 No Damages Unless WPI at least 10%

   (1) An award of damages in a motor accident claim may be made only if the injured person to whom the motor accident claim relates has –

   a. Made an application for qualify of life benefited under Chapter 2 (Motor accident injuries- defined benefits) and has been assessed as having a WPI of at least 10% as a result of the motor vehicle accident; or

   b. Died as a result of the motor accident.

5. Precluding a party from receiving damages for *pain and suffering* unless they can demonstrate that they have been assessed as having a whole person impairment (**WPI**) assessed at 10% takes away such a right. In my view, **no** threshold should exist. Such a threshold doesn't

provide any benefit to the injured party. In fact, it makes it nearly impossible for a party to be compensated for their pain and suffering.

6. Such a threshold allows an insurer to save on paying compensatory damages to an injured party. This means **more profit** for the insurers. This should not be a purpose of the legislation.

7. In my view, **no threshold** should exist.

8. Notwithstanding the above, a 10% whole person impairment is misleading. The common misconception is that a 10% WPI is a low threshold. **This is incorrect**. A 10% WPI threshold is incredibly high and will exclude 90% of injured parties from receiving compensation for their pain and suffering.

9. Parties injured with soft tissue injuries will **not meet** the 10% threshold. Thus, taking away an injured party's right to common law compensatory damages for their pain and suffering.

10. The initial advertised purpose from the Barr Government for the purpose of amending the current scheme was to reduce the amount Canberrans pay for their CTP premiums and to allow universal coverage regardless of fault. In what way does the above section assist the Government in its effort to allegedly reduce the amount that Canberrans will pay for their CTP premiums? **It doesn't.**

11. In what way does the above section assist in providing universal coverage to injured parties regardless of fault? **It doesn't.**

12. Below are a few case studies from New South Wales demonstrating how incredibly high a 10% threshold actually is.

Case Study One **(John – Name changed)**

13. John was unfortunate enough to be involved in a car accident where he suffered the following injuries:
    - Collapse of urinary bladder;
    - Fracture to his left wrist;
    - Abdomen and bowel damage; and
    - Abdomen and wrist scarring.
14. John received a WPI assessment of 6%.

15. Under the current CTP scheme in Canberra, John would be ***entitled*** for monetary compensation for pain and suffering. If the new proposed Bill is passed, that right will be taken away and John will not receive anything.

This is not fair.

***attached is John's WPI assessment.**

Case Study Two **(Jill – Name changed)**

16. Jill suffered the following injuries in her motor vehicle accident that she was involved in:
    - Deformity and scarring to her left breast;
    - Fracture of the left 4th, 5th and 6th ribs;
    - Fracture of the L2 vertebrae of her lumbosacral spine;
    - Dislocation of her right toe and metatarsophalangeal joint;
    - 2nd and 3rd right toe fracture of the proximal phalanges.

17. Jill did not meet the 10% WPI threshold.

18. Under the current CTP scheme, Jill would be entitled to a fair amount in damages for her pain and suffering. If the new proposed Bill is passed, that right will be taken away and Jill will not receive anything.

This is not fair.

***attached is Jill's WPI assessment.**

Case Study Three **(Andrew – Name Changed)**

19. Andrew suffered from the following injuries as a result of the unfortunate car accident that he was involved in:
    - Head – traumatic brain injury;
    - Lung – contusions;
    - Scarring – left thigh, right thigh, right lower leg;
    - Right tibia – fracture;
    - Right femur – distal femoral fracture;
    - Spleen – laceration
    - Thoracic spine – soft tissue injury;
    - Cervical spine – soft tissue injury

20. Andrew's traumatic brain injury and contusions to his lungs were assessed at **0%.**

21. Incredibly, the remaining injuries were found to be no greater than 10%.

22. Under the current CTP scheme, Andrew would be entitled to a fair amouint in damages for the pain and suffering as a result of the traumatic brain injury alone.

23. If the new proposed Bill is passed, that right will be taken away from Andrew.

This is not fair.

***Andrew's WPI assessment is attached.**

24. The above are examples of where individuals have suffered serious and significant injuries as a result of a motor vehicle collision. In the above circumstances, the individuals did not meet the threshold as legislated in NSW. The above examples are at the extreme end from an injury stand point.

25. As someone who acts for and as someone who has acted for hundreds of individuals that have been involved in motor vehicle accidents, the majority of injuries as suffered by individuals in motor vehicle accidents are of soft tissue in nature and require non-invasive treatment in the form of physiotherapy and the like.

26. Individuals that fall into the above majority category will **not meet** the 10% WPI threshold and as a consequence, will **not** be entitled to receive monetary compensation for the pain and suffering head of damage if the new proposed Bill is passed.

This is not fair.

27. The above is one such example demonstrating how this proposed Bill will take away the rights of innocent road users. I would be happy to meet with anyone to discuss many other concerns in relation to the drafting of the proposed Bill.

28. The Jury was not properly addressed on the proposed threshold with some members walking out.

29. Many have not read, discussed or considered the proposed Bill. If passed, the proposed Bill will eradicate a common law right that has stood for generations. I encourage you all to reject the proposed amendments to the current CTP scheme including the introduction of any thresholds.

Canberrans deserve better.

Hassan Ehsan Senior Associate
Maliganis Edwards Johnson
Level 8, 60 Marcus Clarke St, Canberra ACT 2601 | DX 5736
P 02 6257 2999 **F** 02 6257 4422 **E** hehsan@mej.com.au
www.mej.com.au
Maliganis Edwards Johnson

State Insurance Regulatory Authority
Motor Accidents
Medical Assessment Service

Applicant	Respondent
[redacted]	[redacted]

Injured Person's Name:	[redacted]
Date of Birth:	[redacted]
Date of Motor Accident:	[redacted]
Assessed By:	[redacted]
Assessed At:	[redacted]
Date of Assessment:	[redacted]
Date of Certificate:	[redacted]

Certificate

issued under Part 3.4 of the Motor Accidents Compensation Act 1999 (the Act) as to

WHETHER THE DEGREE OF PERMANENT IMPAIRMENT OF THE INJURED PERSON AS A RESULT OF THE INJURY CAUSED BY THE MOTOR ACCIDENT IS NOT GREATER THAN 10%

MAS Matter Number

[redacted]

The following injuries caused by the motor accident give rise to a permanent impairment which **IS NOT GREATER THAN 10%:**

- Right great toe dislocation of metatarsophalangeal joint
- 2nd and 3rd right toe fracture of proximal phalanges
- Right thigh – associated symptoms of lumbar spine non verifiable radiculopathy
- Lumbosacral spine – fracture of L2 vertebrae
- Ribs – fracture of left 4th, 5th and 6th ribs
- Left breast –deformity and scarring

Details of the assessment are set out in the reasons below, which form part of this certificate.

Reasons

1. Dispute Details

The injured person attended at the request of the Medical Assessment Service (MAS) for the purposes of assessment and resolution of the following medical disputes in accordance with Part 3.4 of the Act:

- whether the degree of **permanent impairment** of the injured person as a result of injury caused by the motor accident is greater than 10%.

2. Introduction

I have seen and considered the MAS application form and supporting documents and the MAS reply form and supporting documents.

Details of Who Attended the Assessment

The injured person attended unaccompanied.

List of Injuries to be Assessed

The following injuries, as listed in the referral letter from MAS, were assessed:

1. Right great toe — dislocation of the metatarsophalangeal joint
2. Second and third right toe — fracture of the proximal phalanges
3. Right thigh — meralgia paraesthetica
4. Lumbosacral spine — fracture of L2 vertebra
5. Ribs — fracture of the left 4th, 5th and 6th ribs
6. Left breast — marked deformity and scarring

3. History as Given by the Injured person

Pre-Accident Medical History and Relevant Personal Details

[redacted] completed his secondary education and then undertook work as a teller for the [redacted] for approximately four years.

He worked as a manager for [redacted] for 18 years.

He co-owned a cleaning company with his wife for 22 years, during which he worked in the business for three years.

He was the general manager of [redacted] for 29 years.

He has now been working as the general manager of a crushing company since 2014 to date. He works on a fulltime basis.

He does not describe any previous relevant ongoing musculoskeletal history.

He has undergone a cholecystectomy in the past. He has no ongoing symptoms from this.

He was diagnosed with type 2 diabetes in 1990. He takes Diamicron. He reports undertaking his HbA1c every three months, the last of which was 9%. He reports that this is usually around 7 to 8%.

[redacted] lives on a 5-acre property with his wife. He has two children aged 56 and 54. He does not smoke. He drinks alcohol on a social basis.

He is left hand dominant.

His prior hobbies mainly involved the general maintenance of his property, where he would undertake mowing, planting and whipper snipping for up to 10 hours at a time.

History of the Motor Accident

[redacted] describes a motor vehicle accident on 2 August 2016 in which he was the driver of an automatic vehicle with no other occupants in the car. He reports driving on a road when a car pulled out from behind a truck travelling in the opposite direction and he was consequentially involved in a head on collision with the vehicle. The driver of a truck that had been driving behind him assisted him from the vehicle.

Police and ambulance attended the scene. He was taken by ambulance to Liverpool Hospital. His car was written off.

The airbags were deployed.

At the time, he recalls being mainly concerned about severe chest pain.

History of Symptoms and Treatment Following the Motor Accident

[redacted] remained as an inpatient in hospital for eight days. During this time, he was diagnosed with a haematoma over his left chest.

He also had three rib fractures on the left side of L4, 5, 6.

He sustained dislocation of the metatarsophalangeal joint of the right great toe and fracture of the proximal phalanx of the 2nd and 3rd toe.

He also sustained a fracture to the L2 vertebra transverse process.

Whilst in hospital, he was treated conservatively where he was monitored and provided analgesia.

He underwent physiotherapy for his injuries to the chest and foot.

When discharged, he was provided with a moon boot from his physiotherapist.

He initially remained at home for six weeks. He was able to weight bear with some difficulty and did require some assistance with weight bearing.

During this time, he was treated with analgesia and continued to be monitored by his general practitioner.

Over the six weeks, he reported an improvement of his condition, in that there was decreased swelling from his chest haematoma.

About one month ago, he consulted a physiotherapist in order to attempt to reduce further swelling of the haematoma on the chest.

Overall, he describes a slight improvement of his symptoms over time.

Details of Any Relevant Injuries or Conditions Sustained Since the Motor Accident

There have been no subsequent injuries or conditions.

Current Symptoms

Chest pain

[redacted] describes constant chest pain in the mid sternum and also over both left and right 4th, 5th and 6th ribs.

He does not describe any associated symptoms of paraesthesia or numbness.

He reports an increase of chest pain in the supine position.

He described significant disturbances to his sleep as a result of nocturnal symptoms.

Lower back pain

[redacted] describes constant mid back pain, which extends into his right hip down to the level of his right knee.

He estimates this at a level of 5 to 6/10 using a visual analogue scale (VAS).

He does not describe any associated paraesthesia.

He reports increasing pain with prolonged levels of sitting, particularly when driving.

He describes nocturnal symptoms, which disturb his sleep.

Right foot

[redacted] reports intermittent pain in his right 1st toe when he walks for long periods.

He reports constant pain in the 2nd and 3rd toe, which he describes as an ache and estimates the severity at a level of 4/10. He does not describe any associated symptoms.

He reports that when lying down with a blanket over his toes, the weight of the blanket results in pain.

Physical Tolerances

[redacted] describes an ability to sit for 1 hour. He has some difficulty with standing in one spot for long periods. He does not describe any difficulty with walking.

He reports that prior to the accident, he did shared activities of cooking, groceries and housework.

Since the accident, his wife has undertaken most of the washing and cooking. He does perform some of the vacuuming.

Whereas he used to undertake all of the gardening and whipper snipping for up to 10 hours per week, he is unable to do this currently and contracts to a gardener for this.

Current and Proposed Treatment

[redacted] currently takes Tramadol one to two times a week.

4. Findings on Clinical Examination

Clinical Examination

[redacted] was unable to stand and walk on his toes. He is able to stand and walk on his heels.

CERVICAL SPINE (Cervicothoracic)

There is no muscle spasm or guarding. He demonstrated a full range of movement of his cervical spine.

CHEST

He had a marked haematoma over the left breast. As a result of scarring and organisation of the haematoma, he has been left with a lump and skin retraction from scarring, over an area of 11cm in length and 10cm across. There is no trophic change.

LUMBAR SPINE (Lumbosacral)

There is no muscle spasm or guarding. He has increased lumbar lordosis of his lumbosacral spine.

There is tenderness elicited to palpation over the spinous processes at L2.

He demonstrates the following ranges of movement as a fraction of normal.

Spine movement	Fraction of normal range
Extension	2/3
Flexion	Normal
Right rotation	3/4
Left rotation	Normal
Right flexion	Normal
Left flexion	Normal

He is able to demonstrate straight leg raising to 90° bilaterally. There are no signs of neural tension.

The neurological examination of his lower limbs is normal in terms of tone and muscle strength.

He has bilateral symmetrical reflexes.

There was no sensory loss in a specific anatomical distribution on testing of his lower limbs. There was no muscle wasting evident in his calves.

LOWER EXTREMITY

Right foot

There is no obvious abnormality on inspection of his right foot.

There is tenderness to palpation of the metatarsal heads of the 1st, 2nd and 3rd toes.

He demonstrates a normal range of movement of his hind foot and forefoot.

He demonstrates plantar flexion of 60° and dorsiflexion of 30° at the right great toe MTP.

He demonstrates plantar flexion of 40° and dorsiflexion of 40° of both the 2nd and 3rd toe.

Motion is normal at the remaining toes.

Consistency of Presentation

There are no inconsistencies evident at today's presentation.

5. Review of Documentation

Relevant Imaging Studies and Other Investigations

Ultrasound of the left breast dated [redacted]

reported tissued distorted deep to the long depressed visible scar extending over the left anterior chest wall from above the medial to the left breast obliquely. The area of pronounced scarring extends over 13cm.

Summary of Relevant Documentation

The Personal Injury Claim Form dated [redacted] attributes the following injuries to the motor vehicle accident.

- Expanding haematoma in the left pectoral region
- Closed right first metatarsophalangeal joint dislocation
- Undisplaced fracture to the 2nd and 3rd proximal phalanx of 2nd and 3rd toes
- Multiple rib fractures
- L2 vertebral transverse process fracture

The claim form does not detail any previous relevant medical history.

Medical certificate from [redacted] dated [redacted] opines a diagnoses of expanding haematoma left pectoral region, closed first right metatarsophalangeal joint dislocation, multiple rib fractures L4/5/6 and L2 transverse process fracture.

The ambulance electronic medical record dated [redacted]

Documents that he has diabetes type 2. It reports that he was able to self extricate.

The discharge referral dated [redacted]

Confirms the diagnoses provided in both Personal Injury Claim Form and the medical certificate.

It describes a head on collision where the airbags were deployed. It documents no cervical spine tenderness and full range of unrestricted movement. It documents upper limb bruising of medial left elbow abrasions of the right lateral arm, sternal tenderness and expanding large left pectoral haematoma with tender costal margin. It documents bruising of the right anterior shin, bruising inferior to right great toe and deformity of right great toe.

The right first metatarsophalangeal joint dislocation and fracture was reduced by emergency department staff with post-reduction x-ray being satisfactory. The fractures were managed conservatively by orthopaedics using hard sole shoe and weight bearing as tolerated. The haematoma in the left pectoral region was monitored and treated conservatively in the hospital, during which the haematoma significantly improved. The multiple rib fractures on the left 4th, 5th and 6th were managed conservatively with aggressive physiotherapy from physiotherapists.

The L2 vertebral transverse process fracture was also managed conservatively with no spinal precautions.

[redacted]
diagnosis as previously mentioned.

[redacted]

Confirms a head on collision. It reports that he has not seen any specialists for treatment of his toe or back injuries since leaving hospital and he lost about six weeks off work, where he is the general manager of a company called [redacted] He managed to return to pre-injury duties despite ongoing symptoms. He is not having any current active treatment.

[redacted] records that [redacted] symptoms at the time included discomfort in the chest when sneezing or coughing and discomfort on sleeping on his left side as a result of chest wall injury.

He also records that he has lower back pain for the majority of the time, which radiates down the right lower limb extending to about his knee region.

He documents that [redacted] experiences discomfort of his right foot underneath the base of the 2nd and 3rd metatarsal heads.

He also documented [redacted] symptoms on the tip of his toes. He records that [redacted] had gained full movement of both the metatarsophalangeal and interphalangeal joint of his toes.

Physical examination findings:

Lower back – he demonstrated about three quarters of normal range of movement of the lumbar spine with straight leg raise to more than 60° bilaterally. Neurological examination was within normal limits

Right great toe – normal alignment in his right great toe. Extension of the toe to greater than 30° and flexion of his interphalangeal joint to greater than 30°. There was no callosity present under metatarsal head of great toe.

2nd and 3rd toes – there were no callosities under metatarsal heads of 2nd and 3rd toes. He had extension of metatarsophalangeal joints of both toes to at least 30° and normal alignment present in his foot.

He opined a DRE II from the transverse process of L2 vertebral body fracture for the lumbar spine.

For his great 2nd toe and 3rd toe, he would have equivalent impairment of a person with metatarsal fractures, plantar angulation of metatarsalgia. From Table 64 on page 86, he would have a 10% lower extremity impairment as a result of dislocation of his metatarsophalangeal joint and 2% impairment for his 2nd and 3rd toe fractures. This results in a 14% lower extremity impairment which converts to a 6% whole person impairment.

[redacted]

At the time of the examination, [redacted] documented that he did not complain of specific neck symptoms. [redacted] complained of symptoms when lying on his left side for long periods with tenderness over the sternum. He also recorded constant lower back pain in the midline of the lower back with pain from the right hip down to the side of the knee. He described hypersensitivity of the right great toe and pain on walking.

Physical examination:

- There was no gait abnormality noted.
- He demonstrated a normal range of movement without aggravation of his cervical spine.
- There was marked tenderness along the mid anterolateral costal margin of the left side.
- There was normal range of movement at both hips.
- There was no visible abnormality in relation to MTPJ of the right great toe or along the toe. There was much restriction in the range of movement at the base of the great toe, no measurable plantar flexion and only 10° of dorsiflexion and there was some tenderness along the plantar aspect of the head of the 2nd metatarsal.

He opined 5% whole person impairment for the lower back with 3% dysaesthesia. He also opined 2% whole person impairment for 10° dorsiflexion and MTPJ and marked deformity and scarring of left breast giving 3% whole person impairment.

6. Conclusions

Diagnosis and Causation

Right great toe and 2nd and 3rd right toe

[redacted] does not describe any relevant past history of musculoskeletal complaints in his lower limbs. He describes a head on collision where his right foot was on the accelerator and he was subsequently found to have fractures of his 2nd and 3rd proximal phalanges in his right foot and a dislocation of the hallux metatarsophalangeal joint. The diagnosis is dislocation of the metatarsophalangeal joint of the hallux and fracture of the proximal

phalanges of the 2nd and 3rd toes. This diagnosis is consistent with the mechanism of the accident. This have been caused by the accident.

Right thigh

There is no prior history of lower back pain. After the motor vehicle accident, which is considered significant and involved a head on collision, he sustained a fracture of the transverse process of L2 vertebrae. This is the diagnosis, which has been caused by the accident.

Ribs

He sustained multiple fractures as a result of the head on collision. This is consistent with the mechanism of injury and has been caused by the accident.

Left breast

He had significant haematoma and bruising over the left side of his chest and abdomen. He had a marked haematoma over the left breast. As a result of scarring and organisation of the haematoma, he has been left with a lump and retraction from scarring which defines an area of 11cm in length and 10cm across. This has been caused by the accident.

Right thigh meralgia prosthetica

[redacted]advised that the pain in his right thigh extends from the right buttock to the right hip to the knee. This is on the lateral aspect of his thigh. It is described as more of an ache. There is no dysaesthesia or numbness in this area. Therefore, these symptoms correlate with a non-verifiable radiculopathy with lumbar spinal pain.

Summary of Injuries Listed by the Parties and Caused by the Accident

The following injuries **WERE** caused by the motor accident:

- Right great toe dislocation of metatarsophalangeal joint
- 2nd and 3rd right toe fracture of proximal phalanges
- Lumbosacral spine – fracture of L2 vertebrae
- Right thigh – associated symptoms of non-verifiable radiculopathy. This is considered under the lumbosacral spine impairment.
- Ribs – fracture of left 4th, 5th and 6th ribs
- Left breast – marked deformity and scarring

Permanency of Impairment

Permanent impairment is defined in the American Medical Association's Guides to the Evaluation of Permanent Impairment (4th Edition) (p.315) as follows:

"Permanent impairment is impairment that has become static or well stabilised with or without medical treatment and is not likely to remit despite medical treatment.

A permanent impairment is considered to be unlikely to change substantially and by more than 3% in the next year with or without medical treatment."

The claimant's condition does satisfy the requirements for an assessment of permanent medical impairment.

7. Determinations

Statement about Permanent Impairment

The determination as to permanent impairment is made in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment (Fourth Edition) and the Permanent Impairment Guidelines (1 October 2007).

Degree of Permanent Impairment

1st toe

There is mild restriction of MTP joint extension attracting a 1% WPI, AMA4 Page 78

There is no dorsal displacement of the metatarsal head, so that Table 64, AMA 4, Chapter 3, does not apply.

2nd toe and 3rd toe

The proximal phalangeal fractures have healed and there is no loss of motion. No impairment arises.

Lumbosacral (lumbar) spine

The clinical presentation is consistent with a DRE Lumbosacral Category II impairment rating. There are complaints of low back pain. There is asymmetrical spinal motion. There are non-verifiable radicular complaints.

The presentation does not meet the criteria for radiculopathy set out in Section 4.28 of the MAA Guidelines, page 27.

A 5% Whole Person Impairment rating arises in accordance with the methodology set out in AMA 4, Chapter 3, page 102.

Ribs

There is no rateable impairment in relation to rib fractures (Section 8-2, SIRA Guidelines Page 53

Left breast marked deformity and scarring

Permanent impairment from scarring is rated using the principle of best fit using TEMSKI, Table 8.1, MAA Guidelines, page 53 as follows:

- The claimant is conscious of his scar or skin condition
- Some parts of the scar or skin condition contrast with the surrounding skin as a result of pigmentary change
- The claimant is able to locate the scar or skin condition
- There is no trophic change
- The suture marks are barely visible
- The anatomic location of the scar is not visible with usual clothing
- There is a visible contour defect
- There is a minor effect on activities of daily living arising from the scar itself as there is a deformity resulting in a breast lump and associated with tenderness.
- There is no treatment required for the scar
- There is adherence

Using the principle of best fit, a 2 %WPI impairment arises.

Body Part or System	AMA Guides/ Guidelines References (chapter/ page/table)	Permanent (YES/NO)	Current %WPI*	%WPI* from pre-existing OR subsequent causes	%WPI* due to motor accident
Chest	SIRA, Section 8-2	YES	0	0	0
Lumbar spine	AMA4, Ch 3, pg 102	Yes	5	0	5
Right foot	AMA4, Ch 3, pg 86	Yes	1	0	1
Scarring	TEMSKI, MAA, pg 53	Yes	2	0	2

* %WPI = percentage whole person impairment

Apportionment

Nil

Pre-existing/subsequent impairment

Nil

Effects of Treatment

Nil

A Current % permanent impairment 8%WPI

B Pre-existing/subsequent % permanent impairment	0
C Adjustments % for effects of treatment	0
Final % permanent impairment	**8% WPI**

Signed [redacted]

Name [redacted]

Date [redacted]

State Insurance Regulatory Authority
Motor Accidents
Medical Assessment Service

Matter Number: [redacted]
Applicant:
Respondent:

Injured Person's Name: [redacted]
Date of Birth:
Date of Accident:

RECEIVED
[redacted]
STATE INSURANCE REGULATORY AUTHORITY

Combined Certificate

issued under Part 3.4 of the Motor Accidents Compensation Act 1999 as to

WHETHER THE DEGREE OF PERMANENT IMPAIRMENT OF THE INJURED PERSON AS A RESULT OF THE INJURY CAUSED BY THE MOTOR ACCIDENT IS GREATER THAN 10%

The following injuries caused by the motor accident give rise to a permanent impairment which is not greater than 10%:

- Bladder – collapse of urinary bladder
- Left wrist – fracture dislocation
- Abdomen – bowel damage
- Abdominal and right wrist scarring

Reasons

This is to certify that [redacted] was assessed by the following independent Medical Assessors appointed by the Medical Assessment Service to assess permanent impairment disputes.

Details of the assessments and full reasons are given in the following certificates:

[redacted]

The permanent impairment in relation to the following injuries is 0%.

- Bladder – collapse of urinary bladder

[redacted]

The permanent impairment in relation to the following injuries is 6%.

- Left wrist – fracture dislocation
- Abdomen – bowel damage
- Abdominal and right wrist scarring

Using the Combined Values Chart at page 322 of American Medical Association Guides to the Evaluation of Permanent Impairment, 4th edition, the combined permanent impairment is 6%.

Signed: [redacted]
Assessed by:
Certificate Date:

State Insurance Regulatory Authority
Motor Accidents
Medical Assessment Service

Applicant	Respondent
[redacted]	[redacted]

Injured Person's Name: [redacted]
Date of Birth: [redacted]
Date of Motor Accident: [redacted]

Assessed By: [redacted]
Assessed At: [redacted]
Date of Assessment: [redacted]
Date of Original Certificate: [redacted]
Date of Replacement certificate: [redacted]

Replacement Certificate

issued under Part 3.4 of the Motor Accidents Compensation Act 1999 (the Act) as to

WHETHER THE DEGREE OF PERMANENT IMPAIRMENT OF THE INJURED PERSON AS A RESULT OF THE INJURY CAUSED BY THE MOTOR ACCIDENT IS GREATER THAN 10%

MAS Matter Number
[redacted]

The following injuries caused by the motor accident give rise to a permanent impairment which is 6%:

- **Left wrist – fracture dislocation**
- **Abdomen – bowel damage**
- **Abdominal and right wrist scarring**

Details of the assessment are set out in the reasons below, which form part of this replacement certificate.

Reasons

1. Dispute Details

The injured person attended at the request of the Medical Assessment Service (MAS) for the purposes of assessment and resolution of the following medical disputes in accordance with Part 3.4 of the Act:

- whether the degree of **permanent impairment** of the injured person as a result of injury caused by the motor accident is greater than 10%.

2. Introduction

I have seen and considered the MAS application form and supporting documents and the MAS reply form and supporting documents.

Details of Who Attended the Assessment

The injured person attended and was accompanied by her husband and two children.

List of Injuries to be Assessed

The following injuries, as listed in the referral letter from MAS, were assessed:

- Ribs – fractures 9th to 11th ribs
- Left wrist – radiocarpal dislocation/ fracture styloid process/ trans-scaphoid dislocation/ fracture radial styloid/ permanent sensory numbness of the dorsum surgical reduction of the radiocarpal joint/ injury to superficial branch of the radial nerve/ 4cm scar hypertrophic/ scarring tethered to underlying structures/ left wrist is producing muscle wastaged (sic) below the elbow and above the elbow.
- Right foot – ligament damage and cuboid fracture
- Intestine – intestinal perforation/ surgical and traumatic adhesions to anterior abdominal wall/ ascending colon serosal tear
- Abdomen – intra-abdominal bleeding and muscle damage/ damage to abdominal wall/ scarring (keloid/hypertrophy) measuring approximately 1cm in width above the belly button and narrowing below belly button with a length estimate 10cm – 12cm/ abdominal cramping/ laparoscopy and midline laparotomy performed/ ventral hernia incisional hernia/ traumatic shearing of the subcuteous (sic) fat of the fascia which were surgically debrided/ tear of the inferior and lateral aspect of the left rectus abdominis measuring 2.7cm transverse, 4.7mm AP and approximately 5.6cm long
- Bowel – injury to rectus muscles/ perforation of the small bowel

3. History as Given by the Injured person

Pre-Accident Medical History and Relevant Personal Details

The claimant is married with two children. She lives in her own accommodation, does not smoke cigarettes or drink alcohol, and is right hand dominant.

There was a fractured left elbow at the age of 11 but no other accidents or injuries. She has had no operations or serious illnesses.

The claimant has a [redacted] She was not working at the time of the accident and is now fully occupied looking after her children.

History of the Motor Accident

On [redacted] the claimant was the front seat passenger in a car, wearing a seatbelt, with her seat provided with a head restraint. Fitted airbags were deployed as a result of a head-on collision with another vehicle.

The claimant's car was not driveable after the collision and was written off by the insurance company. Police and ambulance attended and the claimant was taken by ambulance to [redacted] where she was kept for ten days.

History of Symptoms and Treatment Following the Motor Accident

At the hospital, the claimant was found to have fractured ribs, a fractured left wrist and left hand dislocation, as well as a right foot sprain and general bruising. Medical imaging indicated injury for which a laparotomy was carried out and damaged small bowel was found and removed.

An incisional hernia appeared in December 2014 and was repaired shortly afterwards.

The left wrist was treated by open reduction and internal fixation with the orthopaedic hardware being removed in [redacted]

Details of Any Relevant Injuries or Conditions Sustained Since the Motor Accident

Nil.

Current Symptoms

The major problem is described as a feeling of restricted range of motion of the left hand and numbness on the dorsum of the hand.

"Stomach spasms" are described lasting 15-20 seconds on each time they are noted and they may happen on a daily or weekly basis. These have not been noted for the last month. It is thought they are more often experienced as the claimant has been going to the gym or doing other physical activities.

Physiotherapy was carried out for 2-3 months concerning the wrist injury.

The appetite is described as satisfactory and there is no dyspepsia. The weight is stable and the bowels are acting normally.

As concerns activities of daily living, there is no problem with sleeping and driving an automatic car is satisfactory without any significant restrictions.

For leisure, the claimant enjoys watching television and reading.

Current and Proposed Treatment

Seroquel and Latuda have been prescribed by a psychiatrist some three years after the motor vehicle accident.

4. Findings on Clinical Examination

Clinical Examination

Movements were conducted in an active manner by the applicant. Where passive movement has been induced, it has been recorded in the examination findings. Passive movements were not performed beyond the limits of comfort. Where any restriction of movement has been caused by pain, or a mechanical reason or because of any other factor, it has been recorded in the examination findings.

The build, posture and gait were normal. Height 169cm and weight 85kg. There was no difficulty with undressing, redressing or getting on and off the examination couch.

ABDOMEN

A 14cm widened laparotomy wound was noted without any underlying weakness in the abdominal wall. The scar showed a marked colour contrast of which the claimant was very conscious and would like to have this improved. It was easy to locate and slightly hypertrophic with a slight contour defect. It was not adherent to underlying structures.

The abdomen was not tender and there were no abnormal masses felt.

LEFT UPPER EXTREMITY

There was a 4cm surgical scar at the dorsum of the wrist. It was easily viewed and was hypertrophic with marked colour contrast.

The range of motion of the hand and fingers was normal, as was the left wrist with flexion 70°, extension 60°, ulnar deviation 40° and radial deviation 30°, with these measurements being within normal range.

There was dysaesthesia over the dorsum of the hand in the distribution of the radial nerve.

There was no problem with sternal or rib cage compression.

Mid-arm circumference was 31cm bilaterally and maximal forearm circumference was 29cm bilaterally.

There were no remaining problems from the right foot injury.

Consistency of Presentation

There were no inconsistencies with the history, examination or medical imaging findings.

5. Review of Documentation

Relevant Imaging Studies and Other Investigations

[redacted] – CT scan abdomen and pelvis reported [redacted] noting an increase in the volume of abdominal and pelvic free fluid. There was also fluid in the subcutaneous tissue of the abdominal wall. There were minimally displaced fractures of the right 9th to 11th ribs laterally but there was no pneumoperitoneum evident. There was no obvious injury to the intra-abdominal organs.

[redacted] – X-ray left wrist reported [redacted] showing a radial styloid fracture transfixed with a solitary screw with no change in position compared with the previous study from [redacted]

[redacted] – X-ray left wrist reported by [redacted] noting the open reduction and internal fixation of the fractured radial styloid process.

[redacted] – CT abdomen and pelvis with contrast reported by [redacted] noting an umbilical/ peri-umbilical hernia containing loops of small bowel with no evidence of a secondary bowel obstruction.

[redacted] – CT left wrist reported by [redacted] showing an incompletely united fracture of the radial styloid following the open reduction and internal fixation.

Summary of Relevant Documentation

MAS Form 2A

MAS Form 2R

Report of Ambulance Service of NSW dated [redacted] noting pain in the abdomen, right foot, left thoracic region, left wrist, with note of abdominal guarding.

Reports of [redacted] **dated from** [redacted] diagnosing an incisional hernia.

Medical Certificate dated [redacted] noting day of examination on the same day, noting intestinal perforation, intra-abdominal bleeding, fractured 9th to 11th ribs, fracture dislocation of the left wrist, suspected fracture of the right foot and ligament damage.

Medical Reports [redacted] **dated from** [redacted] noting internal fixation of the left radial styloid. On [redacted] there was a left wrist radial nerve neurolysis and removal of the radial styloid screw. The wrist movements were noted to have been quite good.

Statutory Declaration of the claimant dated [redacted] noting multiple right-sided rib fractures, intra-abdominal bleeding and bowel damage, fracture dislocation of left wrist, right foot ligamentous damage, and psychological problems.

Medical Report of [redacted] describing the progress following the motor vehicle accident.

Medical Report of [redacted] **provided for the claimant, dated** [redacted] assessing 9% whole person impairment resulting from reduced range of motion of the left wrist, radial nerve damage, together with an opinion concerning the scarring.

Medical Report of [redacted]**, provided for the insurer, dated** [redacted] finding 2% whole person impairment of the left wrist, noting the problems of scarring of the right wrist, restricted range of motion of the wrist, and interference with the radial nerve to the back of the hand.

Medical Report of [redacted] mentioning a differential diagnosis of psychotic depression or bipolar affective disorder.

Medical Report of [redacted] **provided for the claimant, dated** [redacted] diagnosing an adjustment disorder with depression and anxiety but not providing an assessment of whole person impairment.

6. Conclusions

Diagnosis and Causation

Causation has been found for all claimed injuries from contemporaneous medical documentation.

Summary of Injuries Listed by the Parties and Caused by the Accident

The following injuries WERE caused by the motor accident:

- **Ribs – fracture**
- **Left wrist – fracture**
- **Right foot – soft tissue injury**
- **Abdomen – small bowel injury and subsequent incisional hernia**

Permanency of Impairment

Permanent impairment is defined in the American Medical Association's Guides to the Evaluation of Permanent Impairment (4th Edition) (p.315) as follows:

"Permanent impairment is impairment that has become static or well stabilised with or without medical treatment and is not likely to remit despite medical treatment.

A permanent impairment is considered to be unlikely to change substantially and by more than 3% in the next year with or without medical treatment."

The continuing symptoms affecting the left wrist, including numbness in the dorsum of the hand and episodes of abdominal discomfort, comply with the finding of permanent impairment as required above.

7. Determinations

Statement about Permanent Impairment

The determination as to permanent impairment is made in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment (Fourth Edition) and the Permanent Impairment Guidelines (1 October 2007).

Permanent impairment ratings take symptoms into account, however the percentage whole person permanent impairment is not a direct measure of disability. A finding of 0% whole person impairment indicates there was an injury caused by the motor accident and there may be continuing symptoms, however, relevant guides rate the associated impairment at 0% WPI.

Degree of Permanent Impairment

It is considered the fractured left wrist and the subsequent operation has been satisfactory as concerns the wrist showing a normal range of motion. There is, however, interference with the radial nerve supply to the dorsum of the left hand.

This is assessed with reference to the AMA4 Guides, Table 15, Page 54, with a maximal upper extremity impairment for the sensory component of the distal radial nerve as 5%.

This is modified by reference to Table 11, page 48 where I believe it is appropriate to find Grade 3 category with 60% of the maximum, which is 3% upper extremity impairment, converting to 2% whole person impairment.

The abdominal injury following surgery and repair of the damaged small bowel will have caused the formation of adhesions, with this being classified as a Class 1 impairment from Table 2, Page 239, as the formation of the adhesions has caused anatomic alteration. I have assessed this as 1% WPI.

The abdominal scarring and scarring related to the left wrist surgery has been assessed under the TEMSKI criteria. The scars are basically widened with a marked colour contrast, hypertrophic and visible with ordinary clothing and beachwear in the warmer weather. There is also minor contour defect but not any adhesion to underlying structures. I have assessed the scarring consequently at 3% WPI.

The soft tissue injury of the right foot and rib fractures are considered to have resolved, not being assessable for whole person impairment.

The combined whole person impairment is therefore assessed as 6%.

	Body Part or System	AMA Guides/ Guidelines References (chapter/ page/table)	Permanent (YES/NO)	Current %WPI*	%WPI* from pre-existing OR subsequent causes	%WPI* due to motor accident
1	Left upper extremity	AMA4, Table 15, Page 54 and Table 11, Page 48	Yes	2%	Nil	2%
2	Abdomen	AMA4, Chapter 10.4, Table 2, Page 239	Yes	1%	Nil	1%
3	Scarring (TEMSKI)	Permanent Impairment Guidelines Table 8.1, Page 53	Yes	3%	Nil	3%

* %WPI = percentage whole person impairment

Apportionment

Not applicable.

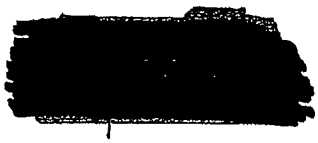
Pre-existing/subsequent impairment

Nil.

Effects of Treatment

A Current % permanent impairment	6%
B Pre-existing/subsequent % permanent impairment	0%
C Adjustments % for effects of treatment	0%

Final % permanent impairment 6%



Signed

Name [redacted]

Date [redacted]