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

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Submission Number: 68 (Part 2)

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Snedden, Andrew

From: James Treloar <JTreloar@mej.com.au>
Sent: Friday, 12 October 2018 10:51 AM
To: LA Committee - JCS
Cc: James Treloar
Subject: Objection to proposed changes to the ACT CTP scheme
Attachments: MAS3.pdf; MAS2.pdf; MAS1.pdf

Importance: High

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

I write to express my strong opposition to the proposed changes to the ACT compulsory third party scheme set out in the *Motor Accidents Injuries Bill* 2018 (**Bill**). I also write on behalf of my many hundreds of clients who, when I have discussed the effect these proposed changes will have on them and their families, also express to me their opposition to the proposed changes.

I query whether all current members of the ACT Legislative Assembly have read the entirety of the Bill? If you have, you will see that if introduced, it will achieve none of the Government's stated aims of providing cheaper, simpler, and more wide-reaching CTP coverage for the average Canberran.

Quite unbelievably, the checks and balances placed on insurance companies under the current scheme will be decimated with much of the oversight and control of the initial process self-regulated by the insurers issuing the policies. There is a clear conflict here. Insurers no duty to act in a Claimant's best interests.

Have we learnt nothing from the recent Royal Commissions into the banking and insurance sectors?

If enacted, the CTP policies issues by the insurers NRMA and Suncorp will, in my view, be a form of 'junk insurance'. Innocent road users will only get a small fraction of their losses.

The concept of broadening coverage to that presently available in the ACT is a desirable one. No one wants to see a repeat of the Sophie Delezio story here. I say that not only as a lawyer, but a father of three young children and a proud member of the Canberran community.

Every time I talk to clients about the changes proposed in the Bill they are in general agreement with the need to provide coverage for such incidents. In other jurisdictions of Australia these are known as 'blameless accidents'. Accidents that occur through no fault of the driver; for example a heart attack, epileptic fit, or as widely publicised by the Government, a kangaroo strike, can be included in the current *Road Transport (Third-Party Insurance) Act* 2008 (**Act**) without the need for such drastic, uncertain and frankly unfair changes as proposed in the Bill.

Surely a better and simpler solution would be to include 'blameless accident' provisions into the current Act, similar to those in Part 1.2 of the *Motor Accidents Compensation Act* 1999 (NSW)?

Costs savings can be found without decimating the current scheme – Ernst & Young and Finity Consulting indicated as much in their discussions with the Citizen's 'jury'.

I would be happy to meet with the Committee, together with the ACT Law Society, ACT Bar, and insurance representatives to discuss how these relatively simple changes could be made to the current Act without gutting the rights of innocent road users – which is *exactly* what this Bill will achieve.

Based on the Government's own modelling (Estimated Costs of Alternative Benefit Designs for the ACT's Compulsory Third Party (CTP) Insurance Scheme, Ernst & Young, 13 March 2018, Page 20) 90 percent of not at fault claimants will be excluded from pursuing a common law claim if these draconian changes are brought into effect.

The insurers couldn't have asked for a better result.

Consider this, there are currently many thousands of ACT Government employees who travel to and from work by car every day. Workers' compensation does not cover injuries sustained by ACT Government employees on 'journey claims' when involved in a motor vehicle accident. However, if that same ACT Government employee is involved in a motor vehicle accident on the way to or from work, he or she is covered under the current Act for pain and suffering, treatment and pharmacy expenses, time off work and domestic care and assistance needs. Under the changes proposed in the Bill – and I again implore you to read the document if you have not already done so – the vast majority of those workers will be left unprotected.

The effect of these changes won't be noticed straight away. It will only be in time, once the harsh realities of the changes face the light of day, then the true inequity of the proposed changes will be known. It is solicitors like myself who will be left with the job of informing those many thousands of persons who will find themselves short in terms of proper compensation, that they will need to purchase alternative insurance to cover what they already have, such as income protection insurance. Alternatively, once the arbitrary time limits under the Bill expire (either 2 or 5 years for treatment and income replacement), those innocent road users will be left to fend for themselves or fall back on Medicare and Centrelink.

The changes proposed in the Bill are drastically unfair. They are also unnecessary to achieve improvements to the current scheme.

I would like to end on this point. It is a common misconception that 10% whole person impairment (**WPI**) is a low threshold. Of course under the Bill, an injured person will not be entitled to common law damages including pain and suffering unless he or she obtains a report from an independent medical examiner (which the injured person has to pay for) who assesses an injured person's WPI as at least 10%: see sections 151 of the Bill and following.

The jury was **not** properly addressed on this issue. Even those who sided with the majority, said as much on the final day of the process.

This is an incredibly harsh threshold to introduce. I have **attached** three recent examples from New South Wales which underline my point.

In the first example, the claimant sustained injuries including:

- A fracture and dislocation of the left wrist;
- Bowel damages and abdominal;
- And right wrist scarring.

That person was assessed with **6% WPI.**

In the second example, the injured person sustained injuries including:

- A right great toe dislocation and metatarsophalangeal joint;
- Second and third right toe fractures of the proximal phalanges;
- Right thigh – associated symptoms of lumbar spine non-verifiable radiculopathy;
- A fracture of the L2 vertebrae of the lumbosacral spine;
- Fractures to 4th, 5th and 6th ribs; and
- Deformity and scarring of the left breast.

This claimant was assessed with **8% WPI.** Yet under the changes proposed in the Bill, if this clamant was injured in the ACT, with the proposed in the Bill she would not be entitled to claim common law damages.

Finally, in the third example, the injured person sustained multiple injuries including:

- A traumatic brain injury;
- Lung contusions;
- Soft tissue injuries to the cervical and thoracic spines;
- A lacerated spleen;
- A distal femoral fracture of the right femur;
- A right tibia fracture;
- A fracture of the femoral shaft of the left femur;
- Scarring of the left thigh, right thigh and right lower leg.

Quite incredibly, this injured person was assessed with **10%** whole person impairment.

Any notion that 10% WPI is a low threshold is simply incorrect and naive.

The introduction of 10% WPI threshold in the ACT will have unexpected and unfair impacts on the average Canberran. **I ask you to please go beyond the headlines of the changes proposed in the Bill and look at the harsh realities that will ensue if it is passed into legislation.** The changes proposed in the Bill will gut the ACT CTP system with the only effects being innocent road users will suffer, and insurer profits will increase.

I would be happy to meet with any or all of you in person to discuss the proposed changes and explain why they should not proceed.

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Maliganis Edwards Johnson

State Insurance Regulatory Authority
Motor Accidents
Medical Assessment Service

RECEIVED
[redacted]
STATE INSURANCE REGULATORY AUTHORITY

Matter Number:
Applicant:
Respondent:

Injured Person's Name:
Date of Birth:
Date of Accident:

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:
Assessed by: [redacted]
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] agnosing 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] oting 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.

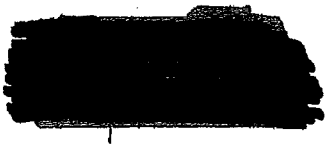
Pre-existing/subsequent impairment

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]

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: [redacted]
Respondent: [redacted]

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

Review 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%

This certificate replaces the combined certificate issued by [redacted]

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

- Head - traumatic brain injury
- Lung - contusions
- Cervical spine - soft tissue injury
- Thoracic spine - soft tissue injury
- Spleen - laceration
- Right femur - distal femoral fracture
- Right tibia - fracture
- Left femur - femoral shaft fracture
- Scarring - left thigh, right thigh, right lower leg

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:

Certificate of [redacted]

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

- Head - traumatic brain injury

Certificate of [redacted]

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

- Lung - contusions

Certificate of [redacted] replacing the certificate of [redacted]

The permanent impairment in relation to the following injuries is **10%**.

- Cervical spine - soft tissue injury
- Thoracic spine - soft tissue injury
- Spleen - laceration
- Right femur - distal femoral fracture
- Right tibia - fracture
- Left femur - femoral shaft fracture
- Scarring - left thigh, right thigh, right lower leg

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 **10%**.

Signed: [redacted]

Assessed by: [redacted]

Certificate Date: 1 August 2016

State Insurance Regulatory Authority
Motor Accidents
Medical Assessment Service

Applicant [redacted]

Respondent [redacted]

RECEIVED
[redacted]
STATE INSURANCE
REGULATORY AUTHORITY

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

Assessment under Review: [redacted]
Assessment conducted by: [redacted]
Date of assessment under review: [redacted]
Date of certificate under review: [redacted]

The above medical assessment was reviewed by a Medical Review Panel comprising of: [redacted]

The medical assessment on review was conducted o[redacted] the request of the Proper Officer.

Review Panel Certificate

issued under Part 3.4 of the Motor Accidents Compensation Act 1999

following a review under section 63 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 ASSESSMENT MADE BY THE REVIEW PANEL UNDER SECTION 63(4) IS AS FOLLOWS:

The Panel revokes the certificate dated [redacted] **nd issues a new certificate determining that:**

The following injuries caused by the motor accident give rise to a whole person impairment which, in total, IS NOT GREATER THAN 10%:

- Cervical spine – soft tissue injury

- Thoracic spine – soft tissue injury
- Lumbar spine – soft tissue injury
- Spleen – laceration
- Right femur – distal femoral fracture
- Right tibia – fracture
- Left femur – femoral shaft fracture
- Scarring – left thigh, right thigh, right lower leg

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

Reasons

1. Review Details

A. Introduction

The medical assessment conducted by [redacted] dated [redacted] was referred to this Review Panel for determination under section 63(3) of the *Motor Accidents Compensation Act 1999*.

All Panel members confirmed that they had no previous involvement with this matter, or with the above injured person. All Panel members also confirmed that there was no conflict or any other reason that they would be unable to approach this review with an open mind.

B. Panel Conference

A teleconference of the Review Panel was held on [redacted] [redacted] acted as the Chairperson of the Review Panel. [redacted] the Proper Officer of the Authority acted as the secretary to the Review Panel.

C. Documentation and Other Material Reviewed

All Panel members confirmed that they had received and considered the following documentation:

1. The certificate including the reasons issued by [redacted]
2. Application form seeking a review and attached documents
3. Reply form and attached documents
4. The determination issued by the Proper Officer on [redacted] referring this matter to a Review Panel
5. All the documents which were provided to [redacted] prior to the assessment under review

2. Assessment under Review

A. Assessment Details

[redacted] had certified the following:

The degree of permanent impairment as a result of the injuries caused by the motor accident, being:

- Cervical spine – soft tissue injury
- Thoracic spine – soft tissue injury

- Lumbar spine – soft tissue injury
- Spleen – laceration
- Right femur – distal femoral fracture
- Right tibia – fracture
- Left femur – femoral shaft fracture
- Scarring – left thigh, right thigh, right lower leg

was greater than ten percent (12% WPI)

The following claimed injuries were found to be not caused by the subject accident:

- Right knee – anterior cruciate ligament

B. Disputes identified by the Parties

The Panel considered the matters cited in the Application for Review (5A) fro[redacted] representing the[redacted] and noted that the following aspects of the assessment were disputed:

- Permanent impairment

The Form 5A from TAC noted that the Applicant believed tha[redacted]ad inappropriately assessed the permanent impairment related to the right tibial fracture. It stated that the method of impairment evaluation that had been used was not consistent with the most specific method in Table 64, page 85 AMA4 Guides and also not in keeping with the MAS Guidance Note number 3.

The Panel considered the Reply (5R) fro[redacted] and noted the Respondent opposed the application for review. They believed that the method of evaluation for the right tibial fracture by[redacted] as appropriate.

3. Matters Considered and Decided by the Panel

The Review Panel considered afresh all aspects of the assessment under review.

A. Evidence Considered

On initial review of the documents the Panel noted that[redacted] had allocated 10% WPI from Table 64, page 85 AMA4 Guides, in relation to the right tibial fracture by analogy with a femoral fracture with malrotation. He had overlooked the other part of Table 64 which specifically provides assessment percentages based on tibial malalignment. The Panel agreed that the usual medical interpretation would be that malalignment includes malrotation, as in[redacted] situation.

The Panel also noted that[redacted] also had not referred to MAS Guidance Note 3 in which it is specifically stated that malalignment is to be considered as including malrotation and provided a recommended method for measuring this. The Panel also noted that Guidance Notes are recommendations to Assessors and are not binding with recommendation that an Assessor should provide reasons for not referring to a relevant Guidance note.

The Panel noted the comprehensive assessment o[redacted] in relation to the other listed injuries.[redacted] also clearly explained that[redacted] has disabilities unrelated to the subject motor vehicle crash that meant he had great difficulty maintaining attention and concentration for the examination.

The Panel considered all of the available evidence and decided that a re-examination of the claimant was not necessary in order to reach a decision, because [redacted] had provided the necessary information to allow review and completion of the evaluation of the permanent impairment related [redacted] injuries.

The Panel decided no additional information was required.

B. Additional Evidence

Not applicable

C. Panel Deliberations

The Panel considered each injury as listed for assessment by [redacted]

The circumstances of the motor vehicle crash were such tha[redacted] sustained multiple skeletal and other injuries. The Panel agreed that criteria for causation were met for each of the listed injuries (noting that they had been correctly redefined by [redacted] with the exception of the listed injury to the anterior cruciate ligament of the right knee (see below).

Cervical spine – soft tissue injury

The findings as set out in [redacted] ertificate show that cervicothoracic DRE I (0% WPI) is the appropriate evaluation. There were "no significant clinical findings" with reference to this spinal region, and there were no symptoms or signs present, that justify assessment of DRE II in this spinal region. Specifically no muscle spasm, no muscle guarding, no dysmetria and no non-verifiable radicular complaints were present. Therefore Panel agreed with [redacted]

Thoracic spine – soft tissue injury

The findings as set out in [redacted] rtificate show that thoracolumbar DRE I (0% WPI) is the appropriate evaluation. There were "no significant clinical findings" with reference to this spinal region, and there were no symptoms or signs present, that justify assessment of DRE II in this spinal region. Specifically no muscle spasm, no muscle guarding, no dysmetria and no non-verifiable radicular complaints were present. Therefore the Panel agreed with [redacted]

Lumbar spine – soft tissue injury

The findings as set out in [redacted] Certificate show that lumbosacral DRE I (0% WPI) is the appropriate evaluation. There were "no significant clinical findings" with reference to this spinal region, and there were no symptoms or signs present, that justify assessment of DRE II in this spinal region. Specifically no muscle spasm, no muscle guarding, no dysmetria and no non-verifiable radicular complaints were present. Therefore the Panel agreed with [redacted]

Spleen – laceration

The findings as set out in [redacted] ficate show that the laceration of the spleen had resolved and was not associated with assessable impairment. The Panel agreed with [redacted]

Right femur – distal femoral fracture

The findings as set out in [redacted] ertificate show that the right distal femoral fracture had been effectively treated and there were no current clinical findings that were associated with assessable impairment. The Panel agreed with [redacted]

Right tibia – fracture

[redacted] had examine[redacted] and found that there were slightly greater than 10° external rotation deformity of the right tibia. This had been assessed with the left leg as the reference (see page 9 of [redacted] Certificate). Table 64 shows 10° to 14° malalignment of the tibial shaft after fracture is

evaluated at 8% WPI. Therefore the Panel disagreed with [redacted] who had determined 10% WPI based on analogy with a femoral fracture.

Left femur – femoral shaft fracture

The findings as set out in [redacted] Certificate show that the left femoral shaft fracture had been effectively treated and there were no current findings that were associated with assessable impairment. The Panel agreed with [redacted]

Scarring – left thigh, right thigh, right lower leg

[redacted] clearly described scarring of the left thigh, right thigh and right tibia. The multiple scars varied in appearance. Based on the information presented, the Panel agreed with the evaluation of these scars by [redacted] being rated at 2% WPI.

Right knee – anterior cruciate ligament

After reviewing all the available information the Panel could not establish an injury to the anterior cruciate ligament had occurred in the subject motor vehicle crash. The Panel agreed with [redacted]

4. Panel Decision

The Review Panel found that the accident WAS a cause of the following claimed injuries:

- Cervical spine – soft tissue injury
- Thoracic spine – soft tissue injury
- Lumbar spine – soft tissue injury
- Spleen – laceration
- Right femur – distal femoral fracture
- Right tibia – fracture
- Left femur – femoral shaft fracture
- Scarring – left thigh, right thigh, right lower leg

The Review Panel found that the accident was NOT a cause of the following claimed injuries:

- Right knee – anterior cruciate ligament

The Review Panel considered that the following injuries give rise to a permanent impairment:

- Cervical spine – soft tissue injury
- Thoracic spine – soft tissue injury
- Lumbar spine – soft tissue injury
- Spleen – laceration
- Right femur – distal femoral fracture
- Right tibia – fracture
- Left femur – femoral shaft fracture
- Scarring – left thigh, right thigh, right lower leg

The degree of whole person permanent impairment of the injuries caused by the accident was calculated as follows:

8% WPI for healed right-sided tibial fracture combined with 2% WPI for scarring provides total WPI of 10% due to the subject accident (Combined Values Chart AMA4).

	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	Cervical spine – soft tissue injury	Chapter 3, page 103 (AMA4)	Yes	0	0	0
2	Thoracic spine – soft tissue injury	Chapter 3, page 104 (AMA4)	Yes	0	0	0
3	Lumbar spine – soft tissue injury	Chapter 3, page 102 (AMA4)	Yes	0	0	0
4	Spleen - laceration	Section 7.4, p 205 AMA4	Yes	0	0	0
5	Right femur – distal femoral fracture	Chapter 3 AMA4	Yes	0	0	0
6	Right tibia - fracture	Chapter 3 AMA4, Table 64, page 85	Yes	8	0	8
7	Left femur – femoral shaft fracture	Chapter 3 AMA4	Yes	0	0	0
8	Scarring	Table 8.1 page 53 MAA	Yes	2	0	2

* %WPI = percentage whole person impairment

Determination Regarding the Degree of Whole Person Impairment of the Injured Person as a Result of the Injuries Caused by the Motor Accident

The total percentage whole person permanent impairment for assessed injuries caused by the motor accident is 10%. Therefore the total whole person impairment is not greater than 10%.

This 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 Impairment Assessment Guidelines.

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

The Review Panel's findings in relation to the degree of permanent impairment of the injuries caused by the accident are different to the findings as stated in the Permanent Impairment certificate issued by [redacted] for the reasons given above. Accordingly, the Review Panel has determined that this certificate is to be revoked and a new Permanent Impairment certificate has been issued by the Review Panel.

5. Issues raised by the Parties

In relation to the issues raised in the application, the Panel agreed that these have all been dealt with in Section 3 above.

6. Panel Certification

The Review Panel notes that more than one assessment has been required to assess the person impairment arising from the injured person's physical injuries.

In accordance with section 61(10)(b) of the Act, the Review Panel has issued a combined certificate combining the result of this review with the results of the other assessments issued in determining this dispute.

This certificate has been viewed by [redacted] who have confirmed that they are in agreement.

Signed [redacted]

Name [redacted]

MEDICAL ASSESSOR ON BEHALF OF THE REVIEW PANEL

Date [redacted]